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Neuropsychiatry and the General Practitioner

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In the army, if a man cannot function as a full-duty soldier, he of necessity must go to the hospital. As a result, the medical officer sees many types of illness much earlier than in civilian life. Some of these are emotional difficulties and every medical officer has become aware of the fluidity of the soma and the psyche in the production of symptoms: gastric, cardiac, orthopedic, and in every body system. The problems arising concern themselves with the understanding of this type of symptomatology: what is the significance of such symptoms? What is the best approach to elucidation and understanding of them? What are the most effective treatment measures for such? The author attempts to answer these questions.

■ JUST as the little World War of 1917-1918 served as an impetus to the development of great strides in the field of medicine, the present World War has produced numerous brilliant advances and achievements. Medicine has always held a unique place in war, being a constructive process in a wholesale destructive effort. There are many factors which make possible the advances that medicine can effect in this situation: it performs in a co-operative fashion and in a uniform and regulated manner as an integral part of a tremendously large machine and, by so doing, can more likely direct its aims in a specified and comprehensive method. Of necessity, the field of preventive medicine must insure the functional capacity of great masses of people, and all efforts can be directed in a fairly well regulated channel in contrast to the dependency on voluntary co-operation of much smaller groups in civilian life. Thus, the new louse powder, DDT, can be effectively and promptly used not on thousands, but literally on millions, of individuals.

Similarly, in clinical medicine, the efficacy of particular drugs or methods tried out in great masses, with the results quickly to be established. All the help of many civilian investigators, clinicians, and laboratories, as well as all of the clinical resources of the Army, can be directed at a focal point with a high degree of efficiency. Thus, the utilization of the sulfa drugs reduced the death rate in meningitis from a figure of 38 per cent in the last war to 4 per cent in this war. With the size of the present Army, this means literally the saving of thousands of lives, plus the indirect benefit to results of such work for civilian health. The pneumonia death rate similarly has been reduced from 28 per cent to 0.7 per cent. The fatality rate of tuberculosis has nearly been eliminated, having been reduced from 7.3 per cent in the last war to 1.8 per cent in this war. It was possible to quickly determine the effectiveness of the prophylactic use of sulpha drugs in the prevention of meningitis by its regulated usage in large numbers of individuals in a relatively short time.

Tremendous advantages have been made in surgery with the use of the sulfa drug, the very wide extension of the use of whole blood, particularly blood plasma in shock, and the develop-

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ment of penicillin, the wonder drug. These, plus the improvements in our methods, have resulted in a reduction of the mortality rate from battle wounds from 8.1 per cent in the last war to 3.5 per cent in this war. It is not surprising to discover these results when we consider that some fifty thousand physicians are devoting their full time to some eleven million men, under circumstances which necessitate the maintenance, as nearly as possible, of the ideal health for the individual.

All the specialized fields of medicine have made advances. Considerable progress has been made in neuropsychiatry, not so much in specific new information that has been sifted and proven, to date, as in its advance through virtue of its wider recognition. In other words, the gain is not measured altogether by what neuropsychiatry has discovered but, rather, by what people in general have discovered about neuropsychiatry. The war has given us an opportunity, a necessity, to examine more than twelve million men, and the responsibility to determine whether they can make the readjustment required to serve in the military forces. We have attempted to help those accepted to make this readjustment, cognizant of the tremendous difference that exists between the way of life of an average American civilian and the nearly antithetical changes required in the Army. Giving up his freedom of action and accepting the strenuous demands of the Army does require a major readjustment and it has been found that many men cannot make this adjustment. The war has forced upon us the necessity to fortify a man to meet battle, to be willing to sacrifice his life, to function under conditions which are beyond the comprehension of anyone who has not experienced them. One of our spectacular discoveries has been the recognition that any man, the strongest of personalities, if subjected to sufficiently severe strain over an indefinite period, may be unable to function. And, finally, we are faced with the necessity to attempt to rehabilitate those men who have evidenced their maladjustment. The war has demonstrated in a dramatic fashion the part emotional factors may play in an individual's motivation to do a job, in the expression of his maladjustment, in the development of physical symptoms, and in the causation of chronic illness.

Among those who have come to have a new appreciation of these facts are the physicians themselves, especially younger men now serving with the armed forces. An even greater challenge and responsibility of the medical profession is to disseminate these findings to the public, in so far as people can be helped by their assimilation and by their understanding. The casualties are returning to civilian life now and will continue to return. It is our opportunity and our responsibility, not only to help these men in their readjustment to civilian life, but to assist their families, their friends, and their communities in the understanding of these casualties.

For reasons of national security until the war is finished, figures cannot be given to indicate the numerical extent of the neuropsychiatric problems in the Army. We do not have the answer to all the problems, although definite strides have been made in the direction of the solution of many of them. The experience has given us several points of specific application of neuropsychiatry to the fields of internal medicine, surgery, and, in some degree, to other specialties. However, before attempting to point these out and in order to give some background for their understanding, it may be pertinent to enumerate the highlights of the neuropsychiatric experience we have had, to date, in the present Army.

Screening

The major lesson learned in the last war and repeated again in this, is the fact that screening serves only the purpose of eliminating grossly abnormal men. It cannot eliminate a large number of individuals who may have made a border-line life adjustment, nor can it possibly eliminate a large number of "normal" men who, under the prolonged stress of environmental and battle conditions, develop maladjustment. The methods used in our induction centers for neurospychiatric screening, now being continuously improved, have not been entirely adequate because of various factors:

1. In a speedy formation of a large Army, we have had to examine rapidly.
2. We have had an inadequate number of qualified nueropsychiatrists. Of roughly 150,000 physicians in this country, there are 3,000 neuropsychiatrists, of which roughly, in turn, thirty per cent are in the armed forces.
3. Until the last few months, we had no system of providing historical data about men examined; con-

sequently, the examiner had to rely entirely upon impressions and verbal communications from the man, obtained in an extremely short contact. With the development of the Medical Survey Program, which is still only getting under way, this further feature will materially help in screening.

Of all the rejections for medical reasons, the neuropsychiatric rejections have accounted for as much as forty per cent during a given month. Considerable concern has been expressed by uninformed individuals over the discovery of such a large incidence of apparent psychopathology and various explanations have been offered, including an indictment of the examination methods in general and the neuropsychiatrists in particular. It has been no surprise to neuropsychiatrists that this segment of the population has been uncovered and it is no special cause for alarm as to the mental health of the nation. This finding does have an important sociological significance, which should not be ignored, and has ramifications into our democratic method of living, our determination to be individualists, and our resentment of authority. It concerns our family life and our educational system. It is intimately linked with the prevailing attitude of the public toward specific service in the Army. To many men, the security of their home, friends, and their job far outweighs their belief in their importance for and their need by the armed forces. The rejection of this group of men for acceptance into the Army has been widely misinterpreted and misunderstood. Too many individuals have regarded the Army as a combination social agency for rehabilitation of bad boys and puny specimens. The Army, like a football team, needs the best and, while every effort has been made and is being made to utilize manpower within the Army, it cannot accept individuals obviously and grossly pathological. The fact that a man may be a regular worker, a community asset, is no indication that he can fit into the Army or be an asset to the Army. Many men can hold a civilian job with efficiency, who would be unable to fit into the regimentation and the discipline of the Army.

Prevention

Once a man is taken into the Army, a major effort is made to help him become an effective soldier. It is recognized fully that the necessary readjustment from civilian life of ease, comfort, and free will, to the Army life of discipline, regimentation, and strenuous existence is a very great one. Recognizing the importance of the neuropsychiatric implications when a man fails to make this adjustment, the Surgeon General has taken steps to place neuropsychiatrists in strategic units of the Army so that they may provide a program of prevention as well as immediate and early consultation with individuals failing to adjust. In every training center, both in the Army Ground Forces and in the Army Service Forces, a mental hygiene consultation service is in operation. The neuropsychiatrists in these centers not only see soldiers in the early stage of maladjustment but, far more important, they present mental hygiene lectures to officers and to enlisted men in training. These lectures were authorized in order that the officers might be more cognizant of the beginning signs of maladjustment in their men, individually and as a group, as well as their own responsibility as a unit commander for the maintenance of morale and mental health. Similarly, in every division, a neuropsychiatrist has been attached to the surgeon's office to carry on essentially the same functions as the neuropsychiatrist in the training center, plus the additional responsibility of treating neuropsychiatric combat casualties. In every large post, the neuropsychiatric section of the station hospital maintains an outpatient clinic, through which, in many instances, it is possible to keep men on duty through psychotherapeutic help provided in one, two, or three interviews with men referred.

Orientation

In addition to specific orientation for officers and trainees relative to mental health, mentioned above, the Army has taken major steps to meet the need to orient men as to their role in the Army. This need is inseparably linked with the even larger field of motivation as to "why we fight." Why should a man be willing to have himself wounded or very possibly killed? Through the Morale Services, orientation officers are placed at various strategic levels: in each post and camp, in each training center, and in each division. It is the aim of this group to provide information on "why we fight" and to orient the soldier as to his role. There is a direct relationship between the state of motivation

and the number of neuropsychiatric casualties. When a man feels that he is not important, that his job is not important, and, as occurs in the Army, when this job is difficult and strenuous, he makes little conscious effort to hold his natural unconscious defeatism in check; consequently, it is essential that every soldier be sold on his own importance, the importance of his job, and the reasons why we must win the war.

Treatment

Despite our best efforts at screening and our best efforts at prevention and orientation, a considerable number of men *do* break down psychologically. Regardless of what we call them diagnostically or the reasons for their breakdown, they do not make good soldiers. It does not help for the officer or the civilian public to become incensed about the frequency with which such difficulties occur, since their emotion does not change the man's personality or his capability to be a soldier. This the Army must decide. The Army, and, more specifically, the Medical Department, assumes the attitude that the man who fails in his initial adjustment is salvageable until proved otherwise. On this basis, immediate treatment is provided in every possible facility. Thus, in combat it has been possible to return from thirty per cent to 50 per cent of neuropsychiatric casualties and, in some areas an even higher percentage than this, back to combat duty. An additional 20 per cent or 30 per cent are salvaged for further duty in the line of communications or the zone of the interior. Within the zone of the interior, psychoneurotic patients were originally hospitalized. Recently steps have been taken to treat this group on a more realistic and practical basis by placing them in uniform in reconditioning units attached to hospitals rather than being ward patients in the hospitals. Gradually more efficient methods of reclassification of these men as to the best type of job assignment are being accomplished, with subsequent reassignment.

Specific Factors Increasing Neuropsychiatric Disability

As has been mentioned above, the motivation of a man becoming a soldier is a very important feature in facilitating his adjustment. The Army has spent, and is spending, much thought and effort in the development of adequate orientation material for our soldiers. From the low level of an Infantry private, we have to recognize that he can see that Russia has been overrun and that their people are anxious to vindicate themselves and reclaim their land. He knows that England has been bombed again and again and that the civilian death rate resulting directly from the war has been of no small figure. He knows that China has been overrun; he knows that Australia has been dangerously threatened. Furthermore, he receives letters and newspapers from home, and he knows what is going on here just as well as we do. If we add up these facts, i.e., his picture, and contrast the hell that confronts him —battle—we may gain a glimpse of the problem of orientation, as well as a factor in the causation of neuropsychiatric battle casualties.

One should not pass over too quickly the plea that we attempt to see his picture, if for no other reason than to grasp a concept of the stress placed on the personality. No one can portray, no one can understand, the hell that that man faces: the constant threat to life; the repeated vision of death, of the maimed, of the wounded; the physical discomforts; the lack of sleep. No one can vaguely portray the emotional stress of even one night in a deep jungle with intense heat, mosquitoes, the screaming of bats and birds, the creeping of animals, with every second filled with the knowledge that there are Jap snipers on all sides.

Then there are other factors operating in the Army which affect the apparent rate of neuropsychiatric casualties. One of the more important of these is the fact that in civilian life if a man develops a headache, if he becomes somewhat emotionally upset, he can take the afternoon off or, if necessary, the week end, or can even go for a vacation. He may never go to a doctor; in fact, he likely does not. On the contrary, in the Army one is either on full duty or he is in the hospital. In civilian life if you wanted to take alka-seltzer or a bromide, it was your free choice. In the Army we have tried to provide men with some sulfa drug but there is no way that we can cater to his individual eccentricities.

On the other hand, it is often not understood that the Army has made very strenuous efforts to utilize men with certain handicaps. The manpower shortage has been such that this is a necessity. The public may fail to recognize that

a very large number of men, some with physical handicaps, some with psychological limitations, are being widely used. In a recent experiment, seventy per cent of the men from three different, specially-created battalions composed of psychoneurotic patients taken from our hospitals were returned to duty. The reconditioning units of our hospitals return many men not only to limited duty but large numbers to full combat duty.

Lessons Applicable to Civilian Practice

From the above vast experience, even at this comparatively early stage in our evaluation of it, certain points stand out as having special significance and definite implications in the civilian practice of medicine.

1. *Co-operative practice.*—One of the greatest compensations in the practice of medicine in the Army is the intimate association between the various specialties and the close co-operation that exists between the men within these specialties. Particularly is this true of neuropsychiatry. Throughout the military forces doctors work in groups and only with very few exceptions are they alone. More accurately, one may say they work in teams: hospital teams, dispensary teams, or regimental or divisional teams, which afford an intimate shoulder-to-shoulder relationship between the surgeon, the internist, the neuropsychiatrist, and all other specialties. Undoubtedly, one of the most important after-effects of the teamwork will be the better understanding among the members of this team—understanding of *each other* and understanding of the *work* in their respective fields. There is no doubt but that the neuropsychiatrist is learning much about medicine and surgery; likewise, the military situation is requiring that the internist and surgeon learn much about neuropsychiatry. We have no qualms in calling consultations; we are not afraid of losing our patients. We are interested in supporting our confreres. With fifty thousand physicians accustomed to and enjoying this opportunity and utilizing this method of group help over a period of two, three, or four years, it can be anticipated that there will be major repercussions in our subsequent civilian practice. It will be the wise civilian physician who, reading the handwriting on the wall, adjusts himself to this method and perhaps even modifies his own practice accordingly.

2. *Soma-psyche fluidity.*—As mentioned above, the circumstances under which medicine is practiced in the Army bring the patient to the physician much earlier than he may have appeared in civilian life. Furthermore, many patients come to the Army physician who would not come to the physician in civilian life. Again, I may state that in the Army a man is either on full duty or else he reports to the dispensary or the hospital, regardless of whether his complaint be anxiety or flat feet, a headache or a fever. It may be that our system of medical education focused our attention so intensely on the anatomical, on the physiological, and on the chemical, that many of us left medical school totally unequipped to evaluate the person that lives in the body. Furthermore, we were so influenced by laboratory findings and x-rays that, for many men, these became more important than their own clinical examinations. As a result, too often patients with functional complaints receive no satisfaction from one physician and keep shopping from another to another. In the Army there is no alternative. The patient has no choice and the physician has ready access to a series of specialists. In every Army installation there is the complete team available for the total examination of a patient and this includes the neuropsychiatrist. When the neuropsychiatrist is competent and helpful, he has more consultations than any other officer in the hospital.

The immediate result is an increased awareness, on the part of all medical officers, of what I choose to term the fluidity between the psyche and the soma. A man's difficulty may be homesickness expressed in terms of gastric distress. It may be anxiety expressed in terms of cardiac irregularity or palpitation. It may be resentment expressed in terms of a low back pain or distress centered around an operative scar. Every medical officer is having the experience of seeing the various and devious ways in which the personality uses the different systems and organs of his body to express his emotions. The alert physician is cognizant of the fact that in the great, great majority of these instances the man is sick, not as he says, but with a definite psychological illness.

We medical officers are seeing many more instances where patients unconsciously exaggerate complaints of illness as the result of anxiety or

fear, and such behavior is usually a manifestation of a psychoneurosis. This type of reaction is not to be confused with malingering, the conscious and deliberate feigning of an illness to escape duty. The essential characteristic of every psychoneurosis is that it represents an unconscious resolution of conflicts and therefore, serves a purpose. The manifestations are as far beyond conscious manipulation as is blushing. Unfortunately, this distinction between unconscious and conscious is often difficult to distinguish. Not infrequently the unconscious mechanism is not recognized and is mistaken by the medical officer as a conscious evasion. To castigate such a patient as a goldbrick is not only scientifically inaccurate but is prejudicial to the man's welfare. The restoration of the patient demands, in the first place, an understanding by the medical officer of the painful situations which cause the soldier's emotional conflict; in the second place, the interpretation of this knowledge to the patient in skillful and understandable terms is a necessity. Understanding the nature of the emotional mechanism by the physician frequently provides the key to therapy and, instead of creating the confirmed invalidism of a chronic psychoneurotic, it frequently transforms an ineffective patient into an efficient soldier. These facts have implications just as truely and just as widely in civilian practice as in the Army practice and the purpose in mentioning it here is to point out again that every medical officer is becoming increasingly aware of the fluidity between the emotions and the bodily systems, the psyche and the soma.

3. *The types of psychosomatic responses.*—Much might be said regarding the wide variety of neuropsychiatric symptomatology observed in the Army hospital. A few comments on certain of these are pertinent for every physician. It is no surprise, under the circumstances in which we practice in the Army, to find that every cardiovascular ward of an Army hospital contains a considerable number of individuals with functional cardiac disturbances. An equally high percentage of functional disturbances are found on the gastro-intestinal ward and there is no small percentage of the same type of individual on the orthopedic wards. In fact, every ward, with the exception perhaps of the acute infectious illnesses, presents a considerable number of these individuals.

Our battle experiences are providing us an opportunity to see a large number of strictly neuropsychiatric cases but, nonetheless, expressed in physical symptoms. There is a large group of individuals in whom the most conspicuous symptom is known as the "startle" reaction. In these there is a motor excitation on the occasion of every noise, particularly if that noise can be associated with battle experience. The patient manifests the reaction by "jumpiness" and exhibts extreme anxiety and fear through the stimulus of any type of noise. Thus, it is recognized that individuals with this type of reaction may have difficulty in going into a subway many months after their battle exposure; they are distressed every time an airplane goes overhead. Another rather large group of individuals can best be described as those having the "shakes." They present a gross tremor of practically the entire body, uncontrollable and intensified with very minor stimuli. Still another psychomotor group are those which present spontaneous tearfulness, acute anxiety, and restlessness. It should be pointed out that every physician connected with combat experience will have had occasion to see many of these types of patients, all of whom, whether they be on the cardiovascular ward or manifest a "startle" reaction, are to be recognized as personality disturbances, as neuropsychiatric problems.

4. *Management of the neuropsychiatric aspects of general cases.*—Certain generalities can be made about the management of the neuropsychiatric aspects of all general medical and surgical cases, particularly the so-called psychosomatic group; i.e., those patients who express their emotions through physical symptoms. This question is perhaps most directly approached by pointing out our common mistakes. These mistakes are made by every physician, in a frequency, depending upon the degree of his understanding and his insight into this type of problem and, on the basis of Army experience, are particularly applicable to our civilian practice.

All too often, the physician fails to take into account the environmental situation in which the man is functioning. Thus, in the Army we recognize there are various specific stresses and, to

fully understand the patient's response, we must carefully scrutinize the stresses of the particular environment. All too often it is assumed that the individual with functional complaints is a "weakling." In this assumption we fail to recognize that he may not be a "weakling" in any sense but the situation may be an extremely difficult one. We have learned in the Army that every man has a potential breaking point and that the integration of his personality may break down when the stress is sufficiently great over a sufficiently long period of time. In other words, we must recognize that many neuropsychiatric casualties, both in the Army as well as in civilian life, may result because the situation is so tough.

A second common error is the assumption that a man's total clinical picture of illness is *either* physical *or* psychological. This either/or concept is totally inaccurate and must be supplanted with an attempt to evaluate how much of the difficulty is physical and how much of it is emotional. It is unquestioned that there will be an element of each in every type of illness, whether it is a psychosis or a broken femur. Obviously, only on the correct evaluation of these factors can appropriate and adequate treatment be given. It is equally erroneous but entirely comparable to treat a case of neurocirculatory asthenia with digitalis as it is to provide only psychotherapy for a cardiac decompensation. All too often the physician assumes that in the absence of physical findings no therapy is necessary or, if the findings indicate only a functional difficulty, that he can pass off the patient with the platitude that nothing is the matter with him. All too often, the physician deludes himself that he is practicing scientific medicine when he hands out some platitudes or placebos.

A third common mistake is our tendency to over-examine the patient and, in too many instances, to over-hospitalize him. Much too frequently the patient is given everything in the gamut of the examinational procedure with the result that he has very good evidence to believe that his case is either very mysterious or else the doctor is a fool. We recognize that the average type of functional disorder, whether it be heart, stomach, or any other organ, unless actually incapacitated, should not be hospitalized further than any necessary investigative procedure necessitates. The physician fails to recognize that this over-examination and over-hospitalization are interpreted by the patient as indicating the serious nature of his difficulty and may very well result in the patient's being all too prone to focus his attention on the physical aspects of his illness rather than the emotional aspects and the necessity to readjust himself to his environmental situation.

An additional common error is the tendency of over-emphasizing a particular finding in an individual case. Often in an attempt to be helpful, the physician may point out that the heart is a little rapid, that there is a trace of albumin, or that there is a quarter of an inch shortening. Every personality is suggestible, some much more than others, and always when a patient comes to a physician he has a lurking concern in his heart of some ominous threat to his well-being. When the physician inadvisedly stresses a particular minor physical finding as if it were important, this, in a sense gives the patient a hook on which he may hang his anxiety. Unintentionally we physicians crystallize and substantiate the patient's misconception of his illness.

Another lesson we have learned in the Army is the tendency of most physicians to underevaluate the necessity for the reconditioning of a patient. The fact that he is able to leave the hospital does not indicate that he is well, nor does it suffice to have him return to the physician's office occasionally for a check up. Psychological factors in reconditioning are grossly ignored. The recovery of every individual from every type of illness is very possibly determined more by his psychological attitude than by any other factor. Through some sort of curious scotoma, the consideration of this factor has been conspicuously absent in most studies of the process of getting well. Because it happens regularly, we assume that the operation will heal, the pneumonia will resolve, the decompensated heart will readjust. We have vaguely been aware of the fact that the recovery of gastric ulcer does have a more direct and obvious relationship to the patient's emotional life. As a whole, we have ignored the emotional life in our general medical and surgical patients both before and after our specific treatment. For practical reasons, in some cases study of the emotional factors before emergency medical or surgical treatment is not so important. After such treatment it should be essential. A lesson learned in the Army is the importance of conscious motivation of the aim to be accom-

plished and our knowledge of unconscious motivation make it obvious that such an evaluation should be made in every convalescent patient. The physician who fails to do so is an offender against his patient, as well as against the best practice of medicine.

Finally, one of our most serious and far-reaching errors is our widespread failure to recognize the psychological factor in all illness, to recognize the struggles of the person who lives in the body, to accept literally the advice to treat the whole person. In the Army the patient has no choice but in civilian life this scotoma of the medical profession is the chief reason for the thriving state of countless quacks and charlatans. Many physicians almost pride themselves on their ignorance of neuropsychiatry. Most of us learned little in medical school that aided us in evaluating the psychological factors in our patients' illnesses. But we must recognize that our loves and our hates, our successes and failures, our joys and our disappointments, are the most potent factors in determining our total state of health. If we acknowledge this, even in our advanced knowledge of bacteria and bullets, we as a profession cannot progress using the tactics of the ostrich toward the contributions of the emotions in the causation and recovery in every type of human ill.

MSMS

FORUM ON ALLERGY

The seventh annual forum on allergy will be held in the Hotel William Penn, Pittsburgh, Pennsylvania, on Saturday and Sunday, January 20-21, 1945. This is a meeting to which all reputable physicians are most welcome, and where they are offered an opportunity to bring themselves up to date in this rapidly advancing branch of medicine by two days of intensive postgraduate instruction. For instance, the twelve study groups, any two of which are open to him, are so divided that those dealing with ophthalmology and otolaryngology, pediatrics, internal medicine, dermatology and allergy run consecutively. In addition, the study groups are arranged on the basis of previous registration. In this way, as soon as the registrations are completed, the registrant is expected to write the group leader and tell him just what questions he wants brought up in the discussion. Attention is also called to the fact that during these two days almost every type of instructional method is employed. Special lectures by outstanding authorities, study groups, pictures, demonstrations, symposia and panel discussions.

The Gastroscope as an Aid to Diagnosis

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Improvements in the gastroscope and the availability of this for diagnosis in last few years has brought about rapid development of this diagnostic procedure which is indicated in all patients with chronic or recurring gastric distress where the x-ray diagnosis is negative or indeterminate or as a check on all ulcers and all malignances to determine operability.

Gastritis which is quite commonly present in patients with gastric complaints can only be definitely diagnosed gastroscopically. The close coöperation between the roentgenologist and gastroscopist is necessary to give the highest percentage of accurate diagnosis.

■ ALTHOUGH the history of the use of the gastroscope in the diagnosis of gastric diseases is extremely interesting and unusual, it will only be recounted here briefly since it has been so adequately summarized by Schindler.[11] It is interesting to note the first earnest attempt at gastroscopy though unsuccessful, was made by Kussmaul in 1868, and later by Mikulicz and Leiter in 1881. Kelling and also Kuttner in 1897 constructed crude instruments to a degree flexible, yet still impractical. In 1907 Chevalier Jackson was trying to develop gastroscopy from esophagoscopy using simple open tubes and in 1908 Loening and Stieda worked out a partially flexible gastroscope with an inner rigid optical tube which slid down into the flexible part once it was *in situ*.

In 1911 Sussmann made a flexible type instrument with an improved optical system. However, it was not until 1932 after several years work in the study of these previous gastroscopes that G. Wolf was able to work out with Rudolf Schindler the flexible gastroscope as it is known today, by using a series of short focusing lenses in a flexible rubber covered shaft, and which enabled them to see the interior of the stomach better than ever before and in a safe manner.

Improvements in the German gastroscope was made after Schindler came to America with the aid of Cameron, who has produced this instrument in this country since 1939. The instrument was strengthened considerably. This was done by substituting for the phosphor bronze spiral, one of stainless steel. This steel spiral is just as flexible but never kinks and keeps the lens system in a perfect coördinated balance. As there are forty-seven elements in the optical system, it is very necessary to have this well protected and in perfect alignment as well as free from soiling. The position of the handle which houses the switch was placed on the same side of the scope as the objective and affords better handling of the gastroscope when working in the lower depths of the stomach.

Taylor[14] described a new type gastroscope in 1941 with a controlled flexibility of the distal part after the scope was *in situ,* by manipulation of a series of wires from a control at the head of the instrument. This type scope presented some mechanical difficulties which has prevented its wide spread use in this country.

The Hardt-Eder[6] Gastroscope, just recently developed and first shown at the Scientific Exhibit of the American Medical Association for 1944 at Chicago, Illinois, is reported by the inventors to have many advantages over previous type instruments. It especially gives a clear picture with a good sized field of vision of about seventy-five degrees, which is mechanically adjustable. It has a semi-flexible outer sheath with a small rigic optical tube, which contains twenty-four lenses that passes down through the outer flexible tube once the *Scope* is inserted and gives more definition and a third dimension.

That gastroscopy was slow to gain favor, particularly in this country prior to 1939 may be attributed to several factors. First, it was a new instrument and had to overcome skepticism as to its safety and value, as relatively only a few had knowledge of its technique and proper training in order to make a satisfactory examination. Availability and safety of such a procedure by competent examiners was therefore one of the first prerequisites. However, in the last five years great strides have been made by training of competent clinicians to use the gastroscope, and today, it is a recognized diagnostic procedure, and the services of a well-trained gastroscopist is demanded in any large progressive civilian hospital or clinic as well as in the various military hospitals.

X-rays, as important as they are in the diagnosis of intragastric pathology, coupled with complete clinical examinations and routine laboratory tests still leaves much in doubt in many cases. If one is to detect early malignancy before too extensive spread of the disease, or to diagnose the various types of gastritis as well as small ulcers and polyps, the diagnosis must be made in the vast majority of casts by the gastroscope.

A high threshold of suspicion must exist in the physician's mind in order to bring about the proper application of various modes of examination in order to detect some diseases of the stomach before they have done irreparable damage. Much too often is the feeling on the part of the busy practitioner that when he is confronted by a patient complaining of some vague upper abdominal pain, to feel that when he has procured an x-ray of the gastro-intestinal tract and the gall bladder, that he has done enough and much too often is satisfied with the reports given him without further questioning. Often lack of interest is shown if the roentgenographic reports are negative, and the patient is endangered by being treated as a neurotic or on the basis of hyperacidity.

As in other fields of medicine, pronounced pathologic disturbances of the stomach are often easy to recognize. It is the milder and less obvious pathological disturbances which tax the ingenuity and resourcefulness of the physician.

Many times although the pathologic alterations are not great, the functional derangements may be most severe and distressing to the patient, and very annoying to the attending physician. Nervousness in different manifestations are apt to be the chief complaints, and endanger the patient with the diagnosis of nervous indigestion. It is therefore of utmost importance not to assume, but to give the benefit of doubt to any patient with gastric distress which persists or recurs.

There is little wonder, when we stop to consider, that the gastric mucosa would not suffer greatly with all the frequent upsets in childhood from indiscrete diets and acute diseases, and also later in life when the mucosa of the stomach is subject to repeated insults from irritating foods, excess condiments, lack of vitamins, excess cof-

fee and alcohol, not to mention the various types of infection and nervous strain.

In patients suffering with digestive disturbance when examined gastroscopically, there are findings of diffuse alteration in the mucosa in forty per cent of the cases. It is of interest to note such gross changes in the gastric mucosa as observed and reported so beautifully by Beaumont on his servant, Alexis St. Martin, where he could directly observe daily through a gastric fistula these changes in the mucosa. These findings, disregarded for a hundred years, are now rediscovered at the gastroscopic examination.

These various reactionary conditions in the gastric mucosa are classified generally under the heading of chronic gastritis. Schindler[9] lists several forms of gastritis, the most important of which are acute and chronic superficial gastritis, atrophic gastritis, and hypertrophic gastritis.

Acute and chronic superficial gastritis have no specific etiological factor, but likely arise from acute illness, chronic foci of infection, vitamin deficiency, and in some chronic debilitating conditions. Later these may change to atrophic gastritis.

When the superficial gastritis changes to atrophy, the clinical picture changes. The gastric symptoms become less marked and the general symptoms come into the foreground of the clinical picture. Weakness and nervousness come in spells, and there is danger that such patients may be treated as a psychoneurotic. Epigastric discomfort and fullness after meals, anorexia, and sometimes nausea, especially if this is accompanied by a sore tongue and paresthesias, is highly suggestive of atrophic gastritis and its concomitant systemic disturbance, and should be treated with large doses of liver and vitamin "B" as well as other measures to improve the general health.

Chronic atrophic gastritis is a very serious disease in as much as it may be a forerunner of pernicious anemia or gastric carcinoma. About one third have anacidity and the remainder as a rule have sub-acidity or normal acidity. It is seen almost constantly in pernicious anemia, and very commonly in pellagra, sprue, and in vitamin deficiency in general. The atrophy may be patchy, localized or diffuse, or complete. When marked, the atrophic areas show a thin, mottled grayish or green gray color and thinning of the rugal folds. Blood vessels are seen through the thin semi-transparent mucosa. Atrophic gastritis may develop within a few months, and then it may remain stationary unless treated. Schindler and Serby[12] suggested that atrophy of the gastric mucosa might be due to a deficiency state. They observed the disappearance of gastroscopic changes of atrophic gastritis in patients with pernicious anemia following adequate liver therapy, and the same has been reported by other observers.

Patients suffering with atrophic gastritis have three times the chance of developing a gastric carcinoma than other healthy adults, therefore, it is our obvious duty to diagnose this disease as early as possible, and to watch these patients closely by frequent x-ray and gastroscopic examinations.

Chronic hypertrophic gastritis is frequent and sometimes very severe. The symptoms are chiefly gastric, and highly suggestive of ulcer. Night pains and delayed pains are frequent. In some cases x-ray examination gives the picture of the so-called 'cob-corn or granulation relief picture, but usually the x-ray is normal and the sovereign diagnostic method is by aid of the gastroscope. The pathological changes are chiefly located in the body of the stomach, rarely in the antrum, and they may be diffuse or circumscript. The gastric mucosa looks swollen, velvety, dull, and the highlights are reduced, nodules and verrucoe are seen. The folds sometimes look segmented. Not infrequently superficial ulceration are observed. These superficial inflammatory ulcerations never appear to develop into true chronic gastric ulcers. Mucosal hemorrhages are often present. Benign gastric ulcers may be single or multiple and may be situated in any part of the stomach. Acute are more common than chronic and more likely to be multiple, but duration usually brief, therefore, less likely to be detected clinically.

Subacute, and chronic ulcer, usually occur singly and most often situated in the region of the lesser curvature. Occasionally of large size, the superficial flat ones tend to bleed, and small funnelshaped ones, to perforate.

It is no longer believed that benign peptic ulcer of the stomach is important as a precancerous condition. The evidence seems to point to the fact that any carcinomatous ulcer is malignant from the beginning.[13] Therefore, it is most advisable to watch roentgenologically and gastro-

scopically all seemingly benign ulcers that are on conservative medical management for complete healing. In the very early stages, a malignant ulcer may simulate a benign ulcer by both morphological methods of diagnosis, and under medical management give indications of healing, even to the point of disappearance of the niche on the roentgenographic plate, but when re-examined gastroscopically in a few weeks or few months after treatment, will then disclose its true identity. In the light of our present knowledge, preventive resection of a benign gastric ulcer to avoid development of carcinoma is hardly advisable.[10]

Benign tumors of the stomach are not rare. Various reports indicate about two per cent of the cases that are scoped have some form of a benign tumor. Of the epithelial type, polyps are the most common, vary in size, and may be multiple, are usually smooth and rounded, and are of the same color as the normal mucosa. They may have a broad base or pedunculated. The surrounding mucosa is normal or atrophic, never hypertrophic. Cauliflower-like papilloma are rare and often turn malignant. No symptoms unless complicated, large or penetrating or obstructing. In this category should be considered the pseudo polyposis, apparently of inflammatory origin growing in the soil of atrophic gastritis. They are usually multiple and occur in hemispherical excrescence.

Benign tumors of the connective tissue type (mesenchymal origin) include such types as fibromas, neuro fibromas, myomas, fibromyomas, lipomas, lymphomas, hemangiomas, and other. Fibromas are the most frequent of this group of benign tumors.

Of malignant tumors of the stomach, cancer is the most important. About 38,000 to 40,000 persons die annually of gastric carcinoma in the United States. About 95 per cent of the patients are between the ages of forty and seventy years. Approximately 30 per cent of all carcinomas found in men and 20 per cent of carcinomas found in women occur in the stomach.

The attitude concerning the prognosis of this fight seems to have changed in recent years, due to better x-ray and gastroscopic examinations and more early and radical surgery, a greater degree of optimism has arisen. About twenty per cent of all patients in whom a gastric resection is done for gastric carcinoma will survive longer than five years. This is gratifying and gives us hopes of discovering and removal of earlier questionable lesions that are found by special examination, such as x-rays and gastroscopy of patients suffering with minor abdominal distress.

Most carcinomas can be seen with the combination of both methods. Some may not be seen by the gastroscope, either because gastroscopy is not possible, as in cases of cardiac obstruction by the tumor, or in cases of leather-bottle stomach in which the stomach cannot be distended by air and therefore, no picture can be obtained, or because in a few cases the carcinoma may really be hidden, lying in one of the so-called blind spots of the stomach. On the other hand, some carcinomas may not be found by x-ray at the first examination and only disclosed by gastroscopic examination.

Balfour[1] states:

> "The difficulties in early diagnosis are primarily responsible for the relatively high incidence of inoperable lesions and the difficulty of recognizing cancer of the stomach early in those cases in which symptoms are lacking probably almost always will be unsurmountable. It is possible, of course, that some easy and accurate routine method of examination of the stomach as part of a general examination may become the rule, just as roentgenologic examination of the lungs is an approach to the elimination of pulmonary tuberculosis.
>
> "Gastroscopy has not only been a distinct aid in early diagnosis of cancer, but it has furnished valuable information on the significance of gastritis in relation to the development of carcinoma. One may expect that the continued use of this procedure will result in a better knowledge of the factors which predispose to cancer of the stomach."

If possible, it is best to establish not just the fact that an intra-gastric lesion is malignant, but to try and differentiate the different types before surgical intervention, as some types give on the average a very good prognosis and others a definitely bad prognosis.

Borrman[2] has given a macroscopic classification of gastric carcinoma which is now widely accepted and which is used widely in the gastroscopic description of gastric tumors. These types can be recognized in the gross specimen; they can be recognized easily at gastroscopic examination, if the whole circumference of the tumor becomes visible; and they can be recognized sometimes at x-ray examination, although the indi-

rect conclusions drawn from even the best relief pictures do not permit statements so definite as does the gastroscopic observation.

Type I carcinoma is of the polypoid variety, which is a rather sharply limited growth, mushroom type, with overhanging edges, surface nodular, ulcerates late, and metastesizes very late. Comprises about three per cent of all types of gastric malignancy. Quite amendable to radical surgery.

Type II carcinoma is of the ulcerating type, rather sharply demarcated, with a rolled nodular margin, deep irregular crater, the floor of which is covered with a dirty brown, dark red or gray exudate. The dark reddish, nodular margin of the ulcer may contain yellowish shallow erosions, and the lesion is quite sharply defined from the surrounding, usually atrophic, gastric mucosa. These lesions comprise about eighteen per cent of all gastric carcinomas and while they grow somewhat rapidly, they do metastasize rather late and therefore, afford extremely satisfactory end results, with cures of long duration if an operation can be performed at not too late a date.

Type III carcinoma of the stomach is an infiltrating lesion of the gastric wall with an irregular ulceration which typically has an irregular wall on one side and the ulceration becomes shallow and blends off into the surrounding mucosa on the other side. It is primarily more of an infiltrating lesion than Type II, and is more malignant. Tends to metastasize at an earlier stage. It comprises about seventeen per cent of the group of gastric carcinomas.

Type IV carcinoma is a diffuse infiltrating type of malignant tumor which comprises about sixty-two per cent of all cases, and is very rapidly growing and metastasizes quite early. It is not sharply limited and spreads rapidly to infiltrate most of the gastric wall, producing a stiff infiltration with formation of nodules and small dirty, necrotic, irregular ulcers. May be scattered throughout the surface or at times, a grayish, cobweb-like membrane forms over the surface without ulceration.

It must not be forgotten that in the beautifully sharp and colorful gastroscopic pictures we see living tissue, that the blood is circulating, that the color is not the dull, grayish pink of the gross specimen after surgery or autopsy, but that there are striking contrasts between the orange-red, brilliant, glistening, normal mucosa, and the yellow, or gray, or yellow-gray, or white, or dirty brown floor of an ulcerated surface.

Therefore, patients in the carcinoma age, in whom an ulcer niche is found at x-ray, should be examined gastroscopically. It probably is no longer necessary to point out that the therapeutic test alone, the watching of the roentgenologic niche becoming smaller, is not sufficient evidence that the ulcer is benign.

Close coöperation between the x-ray examination and gastroscopy will bring about the best diagnostic results concerning gastric carcinoma. X-ray examination, however, is widely known, while gastroscopy is in the beginning of its development. I hope that in a few years the valuable, close coöperation between the two methods will be feasible in all larger communities of this country. X-ray examination, however, will have such good results only if the routine, complete filling of the stomach is used, and if also the modern method of relief technique with compression and with the use of spot device is employed.

It is obvious from the vast experience accumulated in large hospital gastroscopic clinics, that very few cases of gastric carcinoma will be overlooked if the x-ray relief method and gastroscopy are used jointly. The extent of the tumor usually can be well demonstrated by the use of either one or the other method.

In spite of these gratifying developments in the field of early diagnosis, the differential diagnosis, in some cases, between gastric carcinoma and other diseases may be very diffcult even when both methods are employed. The difficulty in differentiating benign and malignant ulcer is well known, and here is a place in which gastroscopy is superior to x-ray examination.

In his paper on benign and malignant gastric ulcers, Palmer[7] came to the following conclusions: Although there is no pathognomonic sign to indicate the benign nature of a lesion, the total evidence available from careful study permits the clinical differentiation of benign and malignant gastric ulcer with a high degree of accuracy. In contrast with the general opinion, this differential diagnosis will usually be possible if all criteria are carefully considered, especially the gastroscopic findings.

Pollard and Scott[8] state that gastroscopy is of particular value in those patients in whom the x-ray examination has been unsatisfactory to either the roentgenologist, the clinician or both.

It is their belief that, if available, gastroscopy should be employed in any patient with an ulcerating lesion of the stomach which is not obviously a carcinoma by x-ray.

The differentiation between benign and malignant ulcerations is at times so difficult that no roentgenologist maintains infallibility. At the University Hospital, Ann Arbor, Michigan and also figures quoted by Drossner and Miller,[3] Walter,[15] and by Eusterman[4] would indicate that the percentage of error on the initial examination by x-ray is between 10 and 20 per cent.

When we review the progress in the understanding of gastric pathology, as it is seen by the gastroscope, then we realize what problems confront us and also that real advancement has been made in the last few years. The gastritis problem remains a broad one, with phases yet to be understood; the control of cancer, a grave one.

The multicentric origin of carcinoma is considered to be two to four per cent of the cases of gastric carcinoma and enhances the possibility of further malignant lesions developing in the remaining portion of the stomach after gastric resection and increases the importance of frequent, careful postoperative observations by the gastroscope.

The modern development of the x-ray method coupled with gastroscopy permits the recognition of almost every gastric carcinoma, even of very small size. It is advisable to have x-ray examination and gastroscopy promptly in patients with apparently minor but definite gastric disturbance if cancer control is to be advanced.

The differential diagnosis of diffusely infiltrative lesions may in the future be helped considerably by gastric biopsy when such has been perfected.

Errors in diagnosis by any one or all methods may at times be present. Even tissue resected for biopsy may be reported as benign by one and malignant by another pathologist. It is always better to err on the side of safety and to have a benign lesion explored and removed for possible malignancy when doubt exists.

Dr. Ewing stated:

"I am quite impressed, as a general pathologist, with the superior conditions under which the gastroscope works over any other method of examining the stomach, because quite clearly when the lesion is in the living body and there is a circulation and you can observe all the various colors and shades and irregularities in the surface examined, you have features which are not provided anywhere else—not even in the surgical operation does the surgeon observe that. I think it is this fact which guarantees the soundness of the principles of gastroscopy and will assure its future development."

The correct diagnosis of intergastric disease is extremely difficult, and the differentiation of benign and malignant lesions of the stomach most important. It requires the full coöperation of the clinician, the laboratory and the roentgenologist, and often the gastroscopist. Careful follow-up examination, after a period of supervised medical treatment and observation by the attending physician is of great importance. Follow-up examination by the x-ray and gastroscope is a most valuable adjunct.

The various types of gastritis which are frequent causes of digestive disturbance are only definitely diagnosed by gastroscopic examination, and particularly the atrophic gastritis which is considered by many authorities as a forerunner of gastric carcinoma, should be discovered and treated as early as possible.

All ulcerating gastric lesions or polypoid like growths discovered by x-ray examination that are definitely not carcinoma should be examined gastroscopically and surgically removed if questionable. Too frequently a malignant lesion has metastasized by the time it reveals itself as such by the x-ray.

In the future, our best weapon for the control of cancer of the stomach is the discovery of and the treatment of any precancerous condition of the gastric mucosa and the early and radical removal of all incipient and small carcinomatous lesions before they have spread to other parts of the stomach and metastasized to other organs.

The importance of the gastroscope as a special diagnostic aid in any intragastric pathology or functional derangement of the stomach where previously a definite and unquestionable diagnosis has not been established by other methods cannot be underestimated.

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MSMS

The Surgical Treatment of Gall-bladder Disease

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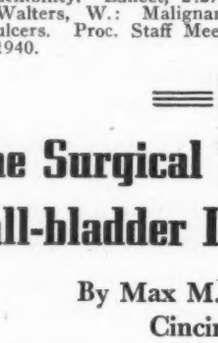

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The physiologic function of the gall bladder is concentration and storage of bile in the intervals between digestive activity. As a result of disease, either metabolic or infectious, this function may be altered or abolished, stones may form, and digestive disturbances occur. The rational treatment of cholecystic disease is cholecystectomy to remove the focus of infection which is principally in the wall of the gall bladder, and to remove the nidus for further stone formation. Symptoms, diagnosis and pathology will be reviewed. The management of acute cholecystitis will be discussed. A few details of operative technique will be mentioned.

■ I HAVE been asked to speak to you about disease of the gall bladder. This I propose to do from the point of view of the surgeon, which, as you know, has to do with removal of the diseased gall bladder. I should, therefore, like to discuss some of the diagnostic features of gall-bladder disease, the reasons why removal is the therapy indicated, and a little about some of the complications.

First of all it seems desirable to review the normal physiologic action of the gall bladder and of bile formation. The constituents of the bile are formed by the cells of the entire reticulo-endothelial system, but principally in the bone marrow, and to a lesser extent in the spleen and liver.[8] It seems likely that the last-named organ is concerned more with the excretion of bile than with its formation. In its passage from the circulating blood through the polygonal cells of the liver into the bile ducts, it undergoes some change, the nature of which is unknown. By the van den Bergh test the difference between the two sorts of bile can be determined, those bile salts which have not gone through the liver cells giving the so-called "indirect action," and those which have gone through those cells and then been reabsorbed into the blood, giving the "direct reaction." The presence of the "direct reaction" is, therefore, indicative of obstruction of the bile ducts, while the "indirect reaction" indicates failure of the liver cells to remove the bile salts from the blood, either due to excess production of the salts or to damage of the liver cells which prevents them from removing normal amounts from the circulation. It is thus indicative of hemolytic or toxic icterus.

The bile is apparently excreted by the liver at a relatively constant rate. In the absence of the gall bladder, it may be discharged into the intestine at a relatively constant rate. When a normal gall bladder is present, it is believed that the bile excreted by the liver enters the bladder through the cystic duct. There water is abstracted from it by the activity of the lining epithelium, thus concentrating the bile salts.[15] When the animal is fasting there is normally no bile discharged into the intestine, and the pressure in the common bile duct in the dog, for example, is about 140-170 mm. of bile. When food is taken there is an immediate flow of brown viscid bile into the intestine. This flow lasts only one to three minutes, but is followed by a secondary flow about ten to twenty minutes later which lasts for several hours. This flow is not continuous but comes in ozes and spurts.[12] From a study of such data it is now believed that the function of the normal gall bladder is to concentrate and store the bile secreted during the

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intervals between digestion until such time as it is required in the intestine.

In addition to direct observation, such as was described above in experimental animals, certain tests and therapeutic procedures confirm these events. The "A," "B" and "C" biles obtained by duodenal drainage and lavage are supposed to represent respectively the bile from the common duct, the concentrated bile from the gall bladder, and the bile from the hepatic ducts partly mixed with bile from the gall bladder. The correct sequence of these kinds of bile, and the examination of them, constitutes one of the tests of gall-bladder disease and the procedure may be used therapeutically to induce so-called internal non-surgical drainage of the gall bladder.

Even more significant and useful is the Graham-Cole test, both for diagnosis and for its aid in helping appreciate the function of the gall bladder. You all know the essential features of this test. A dye is either swallowed or given intravenously. It is excreted in the bile and is sufficiently radio-opague to cast a shadow if it enters the gall bladder in adequate amount and concentration. Many studies of normal and pathologic gall bladders by this test have shown that normally the shadow of the viscus is first more or less indistinct. Later it becomes slightly smaller and much more clear-cut, which is interpreted as concentration of the bile. If food is given, especially food containing oil or fat, the shadow diminishes and finally disappears in thirty to forty minutes, interpreted as the emptying of the gall bladder due to ingestion of food. As a diagnostic test, complete failure of the gall bladder to visualize indicates either (1) failure of the dye to be absorbed, (2) failure of the liver to excrete it, (3) emptying of the gall bladder due to ingestion of food during the progress of the test, or, (4) a non-functioning gall bladder. One can usually eliminate the first three possibilities or take them into consideration in evaluating the significance of a non-visualized gall bladder. By this test stones also may often be demonstrated. In a bladder which is still able to concentrate bile, the stone or stones may be less dense than the dye, and by excluding it, cast negative shadows, or, they may absorb the dye and cast positive shadows best seen after the dye is expelled. The interpretation of abnormalities of shape, size, contour, partial concentration, rate of emptying, et cetera, as shown by the test requires much experience and skill. It is probably our most important single laboratory aid in diagnosis, but must not be regarded as the sole criterion of the presence or absence of cholecystic disease to the exclusion of clinical history and examination.

Some years ago Judd suggested that the term cholecystic disease rather than cholecystitis be used to designate abnormal conditions of the gall bladder for the reason that there seem to be two main sorts of gall-bladder disease—those associated with disturbances of cholestrin metabolism and those due to definite infectious processes. In disease due to disturbance of cholestrin metabolism one may find cholestrin deposits just beneath the epithelial lining of the gall bladder in the submucosa. The wall is generally not thickened, but if the viscus is opened the cholestrin can be seen as yellow flicks through the red mucosa which accounts for the name "strawberry gall bladder" being applied, though a better term is "cholesterosis." Even without actual stone formation such a gall bladder is the cause of or is associated with digestive disturbances which will be described later. When stone forms in this type of cholecystic disease, it is likely to be a solitary stone, oval or round in shape, light in color, and chemically made of almost pure cholestrin. The gall bladder often retains its function of concentration of bile with a stone or stones of this type.

The stones which occur in the course of infectious cholecystic disease are usually made up principally of bile pigments, though they may also contain cholestrin. They are usually multiple, dark in color and irregular in shape. In this type of disease the wall of the gall bladder is generally thick and fibrotic.

Still another type of stone needs to be mentioned. This is the stone which casts a positive shadow in the plain x-ray due to a deposit of calcium on the outside of a stone whose center is made up of cholestrin or bile pigments. As Phemister and his associates have shown this deposition of calcium occurs as a rule only when the cystic duct is occluded.

The symptomatology in the two varieties of cholecystic disease may be similar, except that in the infectious type, the patient may have acute exacerbations with fever and leukocytosis. In

either type, colic and digestive disturbances may be present, but fever and leukocytosis do not occur unless infection is present.

Within the past few years our knowledge regarding how infection reaches the gall bladder has been considerably increased, though there is much that still remains obscure or is subject to doubt and controversy. The possible avenues are (1) the bile and biliary ducts, either ascending or descending, (2) the blood stream, (3) the lymphatics, (4) direct extension from neighboring structures. Apparently infection may reach the gall bladder by all four of these routes, but there is increasing clinical and experimental evidence that the bile and bile ducts which were long considered as the main pathway of infection are of relatively little significance, and that the blood and particularly the lymphatic channels are probably the more important. Chiefly on the basis of experimental work on animals it is now believed that bacteria which ultimately reach the gall bladder, go first to the liver where they are filtered out, and then pass to the gall bladder by way of the lymphatics. The work of Peterman[11] in this connection is especially striking. He has shown that bacteria in the portal blood stream are particularly likely to reach the gall bladder. This, of course, raises the question whether areas of infection in the portal area such as appendicitis, pancreatitis, duodenitis, colitis, et cetera, may not be the principal foci of infection giving rise to cholecystitis. Rosenow[14] believes that most infections reach the gall bladder through the blood stream, and that the localization there is a result of the specific affinity of the particular strain of organisms for the gall bladder. In spite of these experimental findings we must still admit that we do not know with certainty the method or methods by which infection reaches the gall bladder. The experimental production of infection in the gall bladder by injecting large numbers of bacteria into the portal blood stream is not comparable to any clinical happening except rare fulminant infections. It has never been shown, for example, that cholecystic disease is especially prevalent in persons who have previously had acute appendicitis. The frequent occurrence of chronic cholecystitis with chronic appendicitis does not prove that the former is secondary to the latter, nor has it been shown that a chronically infected appendix discharges bacteria into the blood stream; certainly it does not in the numbers that it is necessary to use in experimental work.

There is, of course, a very definite association between cholecystic disease and changes in the liver which are designated by the term hepatitis. In the operating room you are all familiar with the whitish scars visible on the liver in cases of long-standing cholecystic disease. It has been amply demonstrated, however, that microscopic changes can be found in the liver in the absence of gross changes of the surface or even of a freshly cut section. These changes may also be present in the absence of any evidence of hepatic insufficiency as determined by the methods which are now available. The changes seen microscopically consist essentially of infiltration of lymphocytes in the periductal spaces, combined with scarring and fibrosis. How frequently these changes occur in conjunction with cholecystic disease is not clear. According to Graham and his associates, it approximates 100 per cent.[10] Whether it precedes or succeeds the changes in the gall bladder is not entirely certain, but it probably comes first in at least some cases. There is an intimate lymphatic connection between the liver and gall bladder, so that infection in one can easily pass to the other. The function of the liver in detoxification of bacteria and their poisons probably explains in part the changes in the liver described above, as the liver tissue suffers in dealing with these substances. An infected gall bladder is said to be a constant source of renewed infection to the liver both by way of the lymphatic connections and by way of the portal blood stream, and its removal may take away a potent source of infection of the liver.

Of significance from the standpoint of treatment is the location of the infection in the gall bladder. It has been shown that the principal site of infection is not in the bile, not in the lumen, not in the crypts of Luschke, but deep in the wall of the gall bladder. In a study of 200 consecutive cases with stones, Judd[6] was able to obtain positive bacterial cultures from the bile in 14 per cent, from the stones in 31 per cent, and from the macerated wall in 49 per cent. Microscopic examination shows that this portion of the wall is the site of the chief pathologic change. Bacteria injected into the portal stream can be stained in the tissue at this level, and re-

covered from the wall when they cannot be recovered from the bile. These and other observations lead to the belief that the infection lodges chiefly in the wall of the gall bladder, though it seems unlikely that infection lies only in that location.

In the diagnosis of cholecystic disease the history is an important aid. The disability usually consists of indigestion, flatulence, a feeling of fullness after meals, particularly after excessive or injudicious intake of foods. The patient soon learns that certain foods have to be avoided, for if they are ingested an attack is almost certain to occur. Chocolate, eggs, cabbage, beans, fried and greasy foods are the most common offenders. These attacks of indigestion may be isolated or they may be more or less continuous and may be accompanied by fever. They are relieved by rest, by abstaining from food, by the taking of small doses of saline cathartics, and also by duodenal drainage after the method of Lyons. These are the commonly accepted methods of medical treatment. In general we might say of them that they alleviate the symptoms, and often control them very satisfactorily. In the vast majority of cases and especially in those associated with stones, they must be regarded as palliative and temporary measures, but not curative ones. Sooner or later most patients with stones have to have surgical treatment either when their symptoms become too intense or when they tire of the continued disability and treatment.

In addition to the symptoms just mentioned, many patients suffer attacks of acute gall-bladder colic—intense cramp-like pain which begins in the region of the gall bladder and radiates around the ribs or through the body to the right shoulder blade. This is often associated with nausea and vomiting, and may require morphine for alleviation. It is usually due to a stone becoming impacted in the cystic duct, and the colic terminates when the stone has passed down into the common duct or into the intestine, or has slipped back into the gall bladder. In the noninfectious type of stone, fever and leukocytosis are not present, but in the infectious case they may be present and marked. Jaundice is generally absent or slight unless there is stone in the common duct. When present without stone in the common duct it is usually due either to a large stone pressing on the common duct from without, or to inflammatory congestion of the ducts and hepatitis. If the stone remains impacted in the cystic duct, the gall bladder, in the absence of infection, becomes filled with the mucous secretion of its own epithelial cells, and the pathologic condition is called hydrops of the gall bladder. If the contents of the viscus is infected, empyema of the gall bladder may develop.

Examination of the abdomen between attacks may be entirely negative, or there may be slight tenderness on deep pressure over the region of the gall bladder, though during an attack the tenderness may be quite marked and associated with muscle spasm and rigidity. The gastric analysis is not typical, but there is often decreased acidity. Duodenal drainage may show deviation from the normal, either absence of the typical color changes, the so-called "A," "B" and "C" bile, or the presence of abnormal constituents—pus cells, bacteria or cholesterin crystals. Roentgenologic examination of the stomach and duodenum is often negative, but may show evidence of adhesions surrounding the duodenum. Plain films of the region of the gall bladder are usually negative, for even if stones are present they are seldom sufficiently radio-opaque to cast a shadow. The introduction of the Graham test has been of tremendous aid in helping establish the diagnosis.

In the treatment of chronic cholecystic disease there is a consensus of opinion among the leading surgeons both in this country and abroad that cholecystectomy is the method of choice. This opinion is based on a number of things some of which have already been hinted at. The most significant of these is the site of infection in the gall bladder. Experimental study in the laboratory, and pathologic study of clinical material show that this infection is located principally in the wall of the gall bladder so that neither internal nor external drainage can hope to remove it, and cholecystectomy remains the only way of doing so. Another important reason for removing the gall bladder, especially in those cases where stones were present, is that most stones are formed in the gall bladder and more stones may very well develop again in a viscus which has been drained surgically. Another important point is the question of function of the gall bladder before and after surgical drainage. Repeated reports have appeared of groups of patients studied by the Graham test at various in-

tervals after cholecystostomy. They all show that a gall bladder which failed to function before drainage also fails to function after drainage. A few which functioned more or less normally before drainage may continue to function afterwards. In no case is function better after drainage than before.[3,4] If function of the gall bladder cannot be restored by any procedure known to us, and, furthermore, if in addition to being useless the gall bladder is also a source of discomfort and even danger to the patient, then certainly it should be removed.

The intelligent physician wishes to know what physiologic and anatomic changes occur following cholecystectomy. This has been found to vary considerably depending on the condition of the gall bladder prior to operation. If the gall bladder is capable of functioning normally, a number of changes occur, but if it is not functioning, the same sort of changes that occur after removal of a normal viscus have already taken place. In other words, the changes about to be described occur whether the gall bladder is absent so far as function is concerned although anatomically present, or whether it is absent in fact, due to surgical removal. In the walls of the major bile ducts are numerous diverticulæ called parietal sacculi. As a result of functional or anatomic absence of the gall bladder these dilate considerably and thus increase the capacity of the bile duct system.[2] Bile is usually discharged into the duodenum continuously after removal of the gall bladder with increase in the rate of flow during periods of digestion. It is thinner and more watery. Gastric acidity remains unchanged following cholecystectomy, but there is often increase in pepsin. Digestion of fats is less complete in experimental animals after removal of a normal gall bladder. There is some evidence that there is an increase in the virulence of intestinal bacteria particularly those of the B coli group, which may be due to the absence of concentrated bile in the intestine. It is to be re-emphasized that the changes just mentioned are most striking after removal of a normal gall bladder. If a nonfunctioning viscus was present before operation, many of these changes have already taken place.

In addition to the chronic forms of cholecystic disease which have been considered, every now and then patients develop acute infectious attacks. These are usually ushered in by a typical gallstone colic, with pain, nausea, distention and vomiting, but in addition there is fever and leukocytosis. The pain is usually more intense and persistent than with the ordinary attack and the fever may be preceded by a chill. Not infrequently there is slight but definite jaundice. Examination of the abdomen shows it to be slightly distended as a rule, with extreme tenderness in the region of the gall bladder, muscle spasm and signs of a localized peritonitis. If the patient can relax sufficiently, a distended gall bladder can be felt which is very tender to pressure. When such an attack occurs, it has been the custom for years to treat the patient conservatively in the hope that the attack will subside, and since many attacks do subside spontaneously the advice to withhold operation in such cases is generally recommended in textbooks. However, many surgeons believe that most patients with this sort of an attack should be operated upon promptly.

Pathologically there is usually a stone impacted in the goose neck or cystic duct with infection bottled up inside the gall bladder, and the viscus may become filled with purulent exudate, a condition known as empyema of the gall bladder. The coincident infection leads to edema and congestion at the neck of the gall bladder and even to infection extending up the biliary radicles into the liver, which is called cholangiitis. This may cause low-grade jaundice. The infection and congestion may in addition lead, just as in appendicitis, to disturbances in the blood supply to the gall bladder, either by pressure on the cystic vessel or to actual thrombosis. When this occurs, gangrene of the wall of the gall bladder may develop. The advocates of delayed operation or no operation during the acute attack point to the fact that gangrene and perforation of the gall bladder occur infrequently, and that when they do develop, the progress is relatively slow so that adhesions generally have formed, and if the gall bladder ruptures, an abscess outside the gall bladder is formed, the so-called peri-cholecystic abscess. Those who recommend prompt operation in such circumstances point out that if the condition is recognized early, operative removal of the gall bladder is simple and easy to perform, the mortality rate is low and long convalescence and complications are avoided. For many years

I have believed in early operation in patients with acute cholecystic disease.[17] Within the first forty-eight hours of onset, the operation is usually easy to perform, the edema of the wall of the gall bladder facilitates dissection as cleavage planes develop easily. There is increased vascularity and fragility of the vessels, but by proper technique ligation of the cystic artery can be accomplished readily. The convalescence is generally rapid and uncomplicated. In patients seen 48 hours after onset of the attack, cholecystectomy is usually not feasible or recommended, but drainage of the gall bladder may cause the inflammation to subside and prevent perforation of the gall bladder and formation of a peri-cholecystic abscess. Those who recommend nonoperative treatment emphasize that free perforation of the gall bladder is uncommon and with this I agree. However, there has been no published report of which I am aware that gives the mortality rate in cases of peri-cholecystic abscess. Patients with this condition that I have seen are usually extremely ill, the mortality rate among them has been high, and those who recover generally go through a stormy and prolonged convalescence.

In the management of cases of acute cholecystitis seen early I should suggest the following plan: The patient is placed in bed, is given nothing by mouth except sips of water, but fluids are given parenterally. A careful evaluation should then be made of the patient's clinical signs and symptoms such as degree of muscle spasm or rigidity, size and tenderness of gall bladder if palpable, amount of spontaneous pain, temperature and leukocytosis. If the pain is very acute and persistent in spite of opiates, gangrene of the wall of the bladder is probably occurring and prompt operation is indicated. This is especially true of patients over sixty years of age in whom gangrene is more apt to occur early. If the acuteness of the attack moderates within six to twelve hours, operation may be deferred, but if the symptoms or signs persist or get worse I believe operation should be advised. If one is sure of the diagnosis, early operation but not emergency operation is recommended in every case because with such an acute attack operation will sooner or later be necessary, and it is easier to perform during the early acute stage than five days to several weeks later, after adhesions have formed, and the convalescence is usually short and uncomplicated.

I have so far made little or no mention of jaundice and its relation to gall-bladder disease. This is because jaundice is not a symptom of cholecystic disease, but is rather one of the complications. There is insufficient time to consider all the aspects of jaundice or the differential diagnosis of the various types. That which occurs in association with cholecystic disease is usually due to a stone in the common duct. The typical history is one of jaundice associated with colicky pains both of which tend to be remittent or intermittent. Often it is accompanied by chills and fever, due to an associated cholangiitis. The typical temperature chart is characteristic. The chills come at irregular intervals, and are followed by high fever which rises rapidly only to subside just as promptly. This gives a number of steeple-like curves to the chart. In its typical form it is known as Charcot's intermittent or remittent fever, or simply, as Charcot's fever. In patients with marked jaundice, and those with stone in the common duct, the danger to the patient is considerably increased, whatever the treatment.

Many a sufferer from gall-bladder disease who has ultimately died of an operation would probably have survived if operation had been done in an early, uncomplicated stage. Many patients are themselves at fault by refusing operation, but only too often they are kept from operation by a physician who gives them an optimistic outlook for cure without operation, which is not justified. Some years ago Alvarez[1] in reviewing a group of sixty cases found that the average duration of the disease was nineteen years before operation was done. He came to the conclusion that gall-bladder disease was acquired in youth and early adult life, and was recognized and adequately treated in middle and late adult life.

As to the operative technique I have only a few words. The general technique of cholecystostomy and cholecystectomy is well known to you. It is always desirable to divide the cystic duct and artery before removing the gall bladder in order to avoid forcing small stones from the bladder into the common duct and to reduce bleeding. In many cases this may, however, not be the safest way because of the danger of injury to the common duct. When dense adhesions are present as they often are in long-standing cases or those previously operated upon,

so that isolation of the cystic duct is difficult, I always begin the dissection at the fundus and carry it down to the ducts. In extremely difficult cases, the gall bladder may be opened, clamps placed on the margins and a finger inserted into the lumen as a guide. In this way the bladder can be freed somewhat as one dissects the sac of a hernia.

Some surgeons close the wound without drainage following cholecystectomy, an operation to which has been given the name "ideal cholecystectomy." I have never been able to convince myself that this is a wise procedure, and I do not employ it. Whether or not one does do so, depends on whether one is willing to run the risk of leakage of bile. In a simple, easy case without many adhesions, or without much infection, with satisfactory ligation of the cystic duct and artery, it is a perfectly safe procedure except for one uncontrollable factor, namely, the danger of bile oozing from the bed in the liver from which the gall bladder has been freed. Every now and then one finds drainage of bile occurring following the simplest case. Recently Fowler[5] reported on his experience with nondrainage following cholecystectomy. The essential data are as follows: 543 cases were drained, with 15 deaths —a mortality rate of 2.7 per cent; 240 cases were not drained, with eight deaths—a mortality rate of 3.3 per cent. In the follow-up study of these groups there were available 406 drained cases and 134 undrained. Of these, 94.8 per cent of the cases drained report themselves as well, as contrasted with 89.6 per cent of the undrained cases. The author's conclusion was that it was wiser and safer to drain.

Surgery of the common duct at its best is none too easy and requires expert and careful work. At its worst, it ranks with the most difficult surgery and even when good immediate results are obtained the late end-results may be disappointing. Stone in the common duct can usually be recognized by the experienced surgeon by palpation along the course of the duct. If from the history and examination stone in the common duct is strongly suspected, but cannot be located by palpation, the common duct should be explored. The exact criteria to be used in deciding when to open the common duct vary from one clinic or individual to another. The policy in our clinic has been relatively conservative and the following plan is used: The common duct is opened and explored, (1) if a stone can be felt in the duct, (2) if the patient has given a definite history of jaundice or is jaundiced at the time of operation, and (3) if the common duct is dilated. We do not regard the presence of small stones in the gall bladder and a patent cystic duct as a positive indication for opening the common duct unless one of the three conditions just mentioned is also present.

It is usually advisable to drain the common duct after incision or prolonged manipulation. In 1921 Reid[13] and Halsted reported a method of draining the common duct through the stump of the cystic duct, a procedure which they termed cystico-choledochostomy. This method has not been given the prominence in the literature which it deserves. The technique is simple and is illustrated by the lantern slides. After all manipulations of the common duct are completed a small soft rubber catheter, about F 12 or 14, is passed through the stump of the cystic duct and directed downward in the common duct. The incision in the common duct is then closed accurately and carefully by two rows of sutures. We generally use an inner continuous suture of very fine chronic catgut, and a second layer of interrupted fine silk. The catheter is then anchored to the cystic duct by an encircling transfixion suture of fine catgut. We use this method routinely in our clinic in all common duct cases, with the utmost satisfaction. It reduces the time and amount of bile drainage which, when prolonged and copious, is so debilitating to the patient. It thus shortens convalescence and hospitalization and reduces mortality. The long narrow tract usually remains water tight, so that bile leakage around the tube seldom occurs. In most cases the accurate closure of the common duct results in per primam healing, which gives the minimum amount of scarring, and therefore reduces the likelihood of subsequent stenosis of the duct, that much dreaded complication of gall-duct surgery.

In conclusion, I should like to make just a few remarks regarding mortality rates and results following cholecystectomy. I regret that I am not prepared to give you actual figures from our clinic or from my own private practice. In general, however, the mortality rate of cholecystectomy in simple uncomplicated cases has been gradually reduced over a period of years till

(Continued on Page 1112)

Our Medical Veterans' Readjustment Program

President's Page

A Medical Veterans' Readjustment Program to aid returning medical officers of Michigan in a threefold manner was created by the House of Delegates of the Michigan State Medical Society at its 1944 Session in Grand Rapids.

The program's triple activity will assist medical officers with problems of (a) relocation; (b) finances; (c) postgraduate work.

A counselor—a Doctor of Medicine—is to administer the program which will be under the direction of The Council of the State Society.

The House of Delegates, in its wisdom, instructed that a per capita assessment of five dollars be levied in 1945 on every active member of the MSMS to defray the expenses of this postwar veterans' program. Universal enthusiasm for this new and progressive project of the State Society—as well as complete accord with the House of Delegates' decision to continue the ten-dollar assessment for necessary public education activity—has been voiced by members of the medical profession.

Officers of the Medical Corps who are separated from service are invited to utilize this new MSMS Readjustment Service provided for their benefit. The State Society feels it a great privilege and honor to serve our medical veterans upon their return to civilian life.

A. S. Brunk

President, Michigan State Medical Society

EDITORIAL

"MICHIGAN'S MEDICAL PLAN SETS PACE FOR THE NATION"

"In five years the Michigan Medical Service, biggest voluntary venture into the field of medical economics, has become the nation's No. 1 setup of its kind. . . Doctors did everything to put the service within easy reach of all persons. . . . In Michigan, its originators hope that widespread adoption of the prepaid medical plan will cause the defeat of any proposed national legislation designed to put the government in charge of dispensing medical services. . . . There was no difficulty in getting doctors to accept this modified form of social medicine. They set up the plan themselves. . . . The Michigan Medical Society spent thousands of dollars over a period of ten years investigating the possibilities of extending medical service to groups ordinarily unable to afford it."—*The Detroit Free Press,* Sunday, October 15, 1944.

■ A few years ago an article in the public press speaking favorably of the medical profession and its doings would have been a museum article. Now these are appearing frequently. Either the profession has succeeded in selling its good will and good acts, or the bureaucrats who are constantly trying to dominate and control have lost their string, or have met their match. We believe the latter is the case. Our medical service plans have shown that medicine can do its own job without interference. We have demonstrated in Michigan that we have something to offer the public which is far better and much more practical than the dream clouds of the star gazers.

We have been "shown" the Kaiser plan for medical care (DeKruif: "Kaiser Shows the Doctors") and told of its great advance, of its complete care and low cost, of how that plan could be extended to cover so much of the nation. We have before us Kaiser's latest program, the prospectus on which they are selling that plan to the workers of the Kaiser Ship Yards. They are selling "complete health service" except tuberculosis and insanity. Hospital services are available only at the Northern Permanente Hospital located just east of the Vancouver Yard. "The member has available the services of any doctor on the Permanente Hospital staff, or any doctor of the Clark County Medical Society whose name appears in this booklet." The cost is 80c per week for adult member, or wife or husband of member. Children up to three 50c per week each. Children over sixteen are listed as adults.

"Pre-existing chronic illnesses are covered provided the member has been on the new or old plan for 90 days." "A ten-dollar charge will be made for the removal of tonsils and adenoids for child members of the plan under sixteen years of age." "A fifty dollar charge will be made for a maternity case provided the member has been continuously on the plan for at least 90 days prior to entering the hospital." These rates are higher than those in Michigan, and include two extra assessments that we do not. This is the first time the Kaiser employes could get services for the family.

This is the outstanding plan, other than government medicine that has been held up to us as a mark to be attained. We have no fears there.

We should be proud of Michigan Medical Service. Mr. John F. Hunt in his analysis of the public opinion survey, published last month, gave M.M.S. much credit for the favorable opinion he found in Michigan in contrast to other states.

We have a very successful growing concern, we must keep it so. If we do that it can render whatever service our members determine is needful. It can and will be able to outbid the government political setup.

GOVERNMENT MEDICINE AGAIN

■ The American Public Health Association at its annual meeting in New York on October 4, 1944, adopted a report favoring a federal plan of compulsory public health insurance.* This was actually the action of the Governing Council by a vote of 49 to 14. The action was taken in the name of the 7,493 members, of whom only 1,571 are Fellows and have a vote, if they are present. The opposition urged that before taking action they consult the medical and dental professions, who would be most vitally interested in the ultimate plan. But this was not done.

Much as we would like to respect the Ameri-

*(The Report as adopted is on page 441, *Journal of the AMA,* Oct. 14, 1944, and an Editorial on page 434. Read them.)

can Public Health Association we cannot do so. They are decidedly not our friends. Many of their members are members of the American Medical Association, which they know is opposed to this method of government medicine. We think some resignations are in order. This A.P.H.A. is the group that hopes to have control of the bureaucracy in Washington which will administer the Political Medicine that will serve this nation if their recommendation succeeds. The very fact that they ignored the most interested groups in arriving at their policy shows that we have nothing to look forward to in case that ideology should prevail.

This Governing Council contains the names of some of our old "friends" of other controversies: Joseph W. Mountain, M.D., Edwin F. Daily, M.D., I. S. Falk, Ph.D., George St. J. Perrott, Nathan Sinai, D.P.H., to name a few, none of whom are in the private practice of medicine. Salaried bureaucrats, teachers, hospital superintendents, government administrators are not the ones to determine the way medicine shall be practiced in the future. We know their schemes and must circumvent them.

We cannot urge too strongly that every one of our doctors study the material we have given you, and determine where he can help. This is not a job only for your officers. It is a job of the medical profession, and every one of us is involved. It is our practice that is being criticized and its very existence threatened.

THE MICHIGAN PUBLIC OPINION SURVEY

▪ The Michigan Public Opinion Survey, recently completed and just released, shows a quite generally favorable public attitude towards medical-hospital service plans of the prepayment variety and sponsored by the medical profession and hospitals. But a large percentage of our people want government-controlled medical-hospital plans. Study of the reasons for this shows largely that they want security and confidence that they will be taken care of when calamity strikes. The survey also shows that only one person out of four knows about the medical plan, but we have sold our medical services to fifty-four per cent of them. This would seem to point that we have an article for sale that sells very well, but we have not yet pushed it. Yet with the inadequate coverage of the people in our educational efforts we have reduced the number of those favoring government control from fifty per cent as experienced in California to thirty-nine per cent here in Michigan. This is a contrast to the *Fortune* Magazine survey covering the whole country which showed that 74.3 per cent of the people favored government provision of medical care through taxes. Here are facts that show some definite results from the intensive work done in Michigan. *But we have not gone far enough.*

We in Michigan have demonstrated that the Wagner-Murray-Dingell Bill is not necessary. *But we have not gone far enough. We must spread the gospel throughout the nation, as well as do a better job here at home.*

Our survey shows a desire for medical care in the hospital, which the Michigan Medical Service has foreseen; it has provided just such a certificate. As Michigan Medical Service found when it established the present plan, there is no actuarial data upon which to write such a policy. Michigan Medical Service has determined to sell a limited number, forty or fifty thousand, then service those certificates, accumulating our actuarial information in a group that will not bankrupt us, as our other plan nearly did. This is sound practice, and we hope to learn our lessons, and be able to offer this service to all our patrons in reasonable time.

Such a plan and experiment can and will give us the necessary know-how to expand into offering a "Package" more in keeping with what government is talking about.

Another service now being requested is the possibility of selling nation-wide contracts covering surgery and hospitalization for the employes of companies having national distribution of their service. Michigan Medical Servce has found some companies who demand a policy of this scope. There is none of the voluntary type, because there are states where the medical service plan is not yet established.

The Blue Cross service plans through their national associations are especially confronted with this dilema and have proposed the establishment of a Surgical Service plan to be sold in states where no medical plan now operates. This was proposed some months ago, but rather died by the way. However, it is now being revived and

a conference has just been held in New York, the reports of which are not yet available.

We believe this should not be done by the Blue Cross Plans. There would be the same complaint that we had in Michigan that the hospitals were offering medical service. The two plans are best sold together by one sales organization, as is being done in Michigan, but the surgical plan should be sponsored by other surgical plans, of which there are several now successfully operating. None of our surgical plans have as yet accumulated enough funds to finance the new national plan, and they might have to have help from the Blue Cross plans, with proper interlocking boards and controls, but the plans will go farther, and be adopted more generally if they are sponsored through the medical profession.

The above is a service we in Michigan must endorse and help get into being, because this service must be made available if we are to forestall more active encroachment by government in the way of Wagner-Murray-Dingell, or what is more threatening to Michigan right now, the proposed amendment to our State Constitution.

Mr. Hunt in his paper closed with these words: "I might even say—if the facts revealed by this investigation fail to spur you to ultimate effort in perfecting what you have here in Michigan—if they fail to make you just as active in fighting for and providing your kind of medicine on the national stage, the money spent for this investigation will not only be wasted but your profession—as you know it and as you want it—may ultimately be laid waste as well."

POLITICAL MEDICINE

▪ If the medical profession is to retain any vestige of its independence, of its honorable tradition of leadership in public affairs, of being counsellor of its followers, it must WAKE UP. Aggression of every sort is showing its sinister head. There was the Wagner-Murray-Dingell Bill to take over the practice of medicine on a national scale. For the time being that is in the background, but only for the time being. All of these men will be in the next Congress, with the stamp of approval of the voting public. What more logical than that they should take their reelection as a mandate from the people that they carry on in the course in which they have so far made the most noise?

Then there is the threatened Constitutional amendment to the Social Security program of the State of Michigan. Some of our doctors of medicine have been lethargic to this proposal, thinking it was so fantastic it could not possibly be a threat to worry about. A study committee of the State Medical Society has been working on this measure and they have arrived at an opposite view. It has real dangers. If passed, and make no mistake it COULD pass, it will put the medical profession of Michigan out of business. Every one of us will be the hired man of the Commissioner of Social Insurance. Complete medical, obstetrical, surgical, dental, nursing, hospital and pharmaceutical care will be provided for every "normal citizen."

We may feel secure because *"this cannot work."* That may be true; we think it is; but it looks as if an attempt will be made to make it work. The disruption of all our economics, personal or public, in making this attempt at social revolution will be appalling. WAKE UP, Doctor.

ON THE RUN . . .

Two penicillin inactivators are now known: one is the enzyme penicilinase; the other is found in penicillin resistant strains of Staphylococcus aureus.

Stellate ganglion block has been suggested as a means of increasing blood flow in the damaged area following cerebral thrombosis.

Relief from angina pectoris may sometimes be obtained through control of an underlying hyperthyroidism or anemia, reduction of excessive overweight, or support of a protuberant abdomen.

Pulmonary tuberculosis is much more of a surgical disease than is duodenal ulcer; 50 to 80 per cent of the former are now treated surgically as against 10 to 15 per cent of the latter.

In supposed functional diarrheas, a high blood sedimentation rate indicates organic trouble in the bowel.

Prostatic calculi occur as frequently in malignancy of the gland as in benign hyperplasia.

Renal tuberculosis should be suspected in every instance of pyuria.

Carcinoids (argentaffine tumors) of the small bowel produce a characteristic sharp angulation in x-ray studies of the involved segment.

Cutting of pleural adhesions has more than doubled the instances where an ineffective pneumothorax has been made effective.

—Selected by Wm. S. Reveno, M.D.

MICHIGAN STATE MEDICAL SOCIETY

Seventy-ninth Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Pantlind Hotel, Grand Rapids, Michigan

Monday Evening Session

September 25, 1944

The first session of the House of Delegates of the Michigan State Medical Society convened at eight thirty-five o'clock in the Ballroom of the Pantlind Hotel, Grand Rapids, Michigan, with P. L. Ledwidge, M.D., M.D., Detroit, the Speaker, presiding.

THE SPEAKER: The House will please come to order. Is the Chairman of the Credentials Committee ready to report?

I. Record of Attendance

	COUNTY	DELEGATE	MEETING 1st	2nd	3rd
1.	Allegan	W. C. Medill	x	x	x
2.	Alpena-Alcona-Presque Isle	F. J. O'Donnell	x	x	x
3.	Barry	C. A. E. Lund	x	x	x
4.	Bay-Arenac-Gladwin-Iosco	C. L. Hess	x	x	x
		F. H. Drummond	x	x	x
5.	Berrien	D. W. Thorup	x	x	x
6.	Branch	R. L. Wade	x	x	x
7.	Calhoun	A T. Hafford	x	x	x
		B. G. Holtom	x	–	x
8.	Cass	S. L. Loupee	x	x	x
9.	Chippewa-Mackinac	B. T. Montgomery	x	x	x
10.	Clinton	W. B. McWilliams	x	x	x
11.	Delta-Schoolcraft	J. J. Walch	x	x	x
12.	Dickinson-Iron	L. E. Irvine	x	x	x
13.	Eaton	P. H. Engle	x	x	x
14.	Genesee	D. R. Brasie	x	x	x
		F. E. Reeder	x	x	x
		Henry Cook	x	x	x
		A. C. Pfeifer	x	x	x
15.	Gogebic	W. E. Tew	Not Repres'd.		
16.	Grand Traverse-Leelanau-Benzie	R. T. Lossman	x	x	x
17.	Gratiot-Isabella-Clare	M. G. Becker	x	x	x
18.	Hillsdale	L. W. Day	x	x	x
19.	Houghton-Baraga-Keweenaw	Alfred LaBine	x	x	x
20.	Huron	C. W. Oakes	x	x	x
21.	Ingham	C. F. DeVries	x	x	x
		L. G. Christian	x	x	x
		R. S. Breakey	x	x	x
22.	Ionia-Montcalm	W. L. Bird	x	x	x
23.	Jackson	J. J. O'Meara	x	x	x
		C. S. Clarke	x	x	x
24.	Kalamazoo	R. J. Armstrong	x	x	x
		L. W. Gerstner	x	x	x
25.	Kent	R. H. Denham	x	x	x
		L. F. Sevey	x	x	x
		A. B. Smith	x	x	–
		A. V. Wenger	x	x	x
		W. B. Mitchell	x	x	x
26.	Lapeer	D. J. O'Brien	x	x	x
27.	Lenawee	E. T. Morden	x	x	x
28.	Livingston	H. L. Sigler	x	x	–
29.	Luce	H. E. Perry	Not Repres'd.		
30.	Macomb	Wm. A. Sibrans	x	x	x
31.	Manistee	E. A. Oakes	x	x	x
32.	Marquette-Alger	W. H. Vandeventer	x	x	x
33.	Mason	C. A. Paukstis	x	x	x
34.	Mecosta-Osceola-Lake	Paul B. Kilmer	x	x	x
35.	Medical Society of North Central Counties	R. C. Peckham	x	x	x
36.	Menominee	S. C. Mason	x	x	x
37.	Midland	Harold H. Gay	x	x	x
38.	Monroe	T. A. McDonald	x	x	x
39.	Muskegon	E. N. D'Alcorn	x	x	x
		Harold Dykhuizen	x	x	x
40.	Newago	H. R. Moore	x	x	x
41.	Northern Michigan	George Wood	x	x	x
42.	Oakland	R. H. Baker	x	x	x
		P. E. Sutton	x	x	x
43.	Oceana	M. G. Wood	Not Repres'd.		
44.	Ontonagon	W. F. Strong	Not Repres'd.		
45.	Ottawa	A. E. Stickley	x	x	x
46.	Saginaw	C. E. Toshach	x	x	x
		L. C. Harvie	x	x	x
47.	Sanilac	R. K. Hart	x	x	x
48.	Shiawassee	C. L. Weston	x	x	x
49.	St. Clair	Geo. Waters	x	x	x
50.	St. Joseph	R. A. Springer	x	x	x
51.	Tuscola	John C. Shoemaker	x	x	x
52.	Van Buren	Wm. R. Young	x	x	x
53.	Washtenaw	R. N. DeJong	x	x	x
		J. S. DeTar	x	x	x
54.	Wayne	W. D. Barrett	x	x	x
		G. L. McClellan	x	x	x
		S. W. Insley	x	x	x
		R. L. Novy	x	x	x
		A. E. Catherwood	x	x	x
		H. F. Dibble	x	x	x
		L. W. Hull	x	x	x
		T. K. Gruber	x	x	x
		R. H. Pino	x	x	–
		H. A. Luce	x	x	x
		D. C. Beaver	x	x	x
		F. G. Buesser	x	x	x
		W. H. Honor	x	x	–
		R. C. Jamieson	x	x	x
		R. V. Walker	x	x	x
		L. J. Morand	x	x	x
		W. W. Babcock	x	x	x
		W. B. Harm	x	x	–
		L. J. Bailey	x	x	x
		W. S. Reveno	x	x	x
		C F. Brunk	x	x	x
		M. A. Darling	x	x	–
		C. K. Hasley	x	x	x
		C. E. Simpson	x	x	x
		B. H. Douglas	x	x	x
		E. G. Krieg	x	x	x
		Arch Walls	x	x	x
		T. G. Amos	x	x	x
		V. N. Butler	x	x	x
		A. F. Jennings	x	x	x
		R. A. Johnson	x	x	x
		J. A. Kasper	x	x	x
		H. L. Clark	x	x	–
		C. S. Ratigan	x	x	x
		Duncan Campbell	x	x	x
		W. S. Gonne	x	x	x
		F. A. Weiser	x	x	–
		J. E. Cole	x	x	x
		R. C. Connelly	x	x	x
		J. H. Andries	x	x	–
		S. E. Gould	x	x	x
		W. J. Smith	x	x	x
55.	Wexford	P. L. Ledwidge	x	x	x
56.	Speaker	L. Fernald Foster	x	x	x
57.	Secretary	H. H. Cummings	x	x	x
58.	Immediate Past President				

J. J. O'MEARA M. D.: Mr. Speaker, I hold here in my hand, the credentials of 100 members who are delegates to the Michigan State Medical Society, 50 per cent of whom are not from any one county.

I hereby declare this session in order.

THE SPEAKER: If there are no objections to the Credentials Committee's report, we will consider it the roll call for this meeting.

Now, there is a question before the House to decide before we can proceed with our regular work. There is a question about whether or not one delegate can be seated. That involves another matter which shall be discussed later in the meeting. I will ask Dr. Foster to read now a petition which has been presented by the Council and as soon as that has been read and explained, then the House will take action on the possible seating of this delegate.

SECRETARY FOSTER: Mr. Speaker and Members of the House. This petition is being read and presented for action later. It is a petition of the Chairman of the Council to the House of Delegates, September 24, 1944.

VII—1. SEATING OF A DELEGATE

Petition re: Chippewa-Mackinac County Medical Society

At the meeting of The Council of the Michigan State Medical Society held today, September 25, 1944, The Council, with the affirmative vote of two-thirds of all the members thereof, adopted a Resolution that it recommend to the House of Delegates of the Michigan State Medical Society that the charter of the Chippewa-Mackinac County Medical Society be revoked, inasmuch as The Council feels that this County Medical Society has conducted itself in such a manner as to make such revocation desirable in the best interests of this Society. This action was taken in accordance with Chapter 1, Section 2 of the MSMS By-laws (Page 87 of the Handbook for Delegates).

The Council further recommends to the House of Delegates that any representative of the Chippewa-Mackinac County Medical Society who may present himself to be seated as a Delegate in the 1944 House of Delegates of the Michigan State Medical Society *be not seated,* as The Council feels, basing its opinion on exhaustive investigation made by the MSMS Ethics Committee, that a question exists concerning the legality of the election of *any* Delegate to the MSMS House of Delegates from this County Medical Society.

Therefore, in conformance with the By-laws, it is my duty to file with the Secretary of the Michigan State Medical Society this written petition signed by me, as Chairman of The Council.

Respectfully submitted,

V. M. MOORE, M.D.
Chairman of The Council
Michigan State Medical Society

SECRETARY FOSTER: The Speaker has asked me to give you a very short résumé of the situation in this particular component county society.

For a number of years, a condition has existed in the society that finally culminated in a charge of unethical conduct against some of the members, resulting in the expulsion of three of its members. These members, by their prerogative of state society membership appealed to the Councilor and to the Council. The Council referred the matter to its fact-finding Committee on Ethics which has held a hearing and made an exhaustive study of the charges involved in the conduct of these members. It made its recommendation and its report back to the Council at its midsummer meeting.

In view of the lack of evidence on some of the charges, the Council at its July meeting took action to the effect that the charges were not sufficiently substantiated to warrant the type of action taken by this Society and the Council further directed that a meeting of this Society should be held in September of this year to be conducted by the Councilor of the Twelfth District who should conduct the meeting with a view toward a reorganization of this group. A quorum, or a majority of the members in good standing as of December, 1943, was not present, and as a result, no meeting was held.

The action of the Council today is in line with that action taken in July, at which time the Council decided that the election of officers in that component county society raised a question of legality of election and as such, the Council refused to accept officially, the election of the slate of officers as presented.

It was the feeling of the Council, therefore, that no organization existed insofar as their recognition of their officers was concerned. Therefore, it was felt that if that were true and if the conditions in that county have reached a stalemate, which they apparently have, they could not justify the seating of a delegate from the Society whose election they had not approved.

I give you that background so you will understand the reason for the presentation to this body of this petition to be acted on later.

THE SPEAKER: Thank you, Dr. Foster. If you will please turn now to page 87 of your Handbook, the By-laws, Chapter 1, Section 2, you will find the section under which this action has been recommended. You may consider the statement made by Dr. Foster; the petition being read and the explanation given, as notices of hearing. This hearing will be held at our session tomorrow evening, after all of these things that Dr. Foster has mentioned briefly will be gone into detail. After that is done, if the House feels that it is then ready to take action on this matter, you will have a chance to do so.

Now, at this time, I would like to present the petition of B. T. Montgomery, M.D., of the Chippewa-Mackinac Medical Society. Dr. Montgomery is here with credentials signed by his County Secretary. Under the circumstances he cannot speak for himself and it is my privilege to speak for him. He petitions he be seated and it is up to the House of Delegates to seat him or not, as they see fit. He represents Chippewa County where this trouble is going on.

Are you ready for the question? All in favor of seating Dr. Montgomery, please stand—.

L. G. CHRISTIAN, M.D. (Ingham): I know nothing of this, but it seems to me that an indictment has been brought in.

THE SPEAKER: Dr. Christian, if you don't mind, I don't believe this is discussable. I think it is a question for each man to decide for himself.

DR. CHRISTIAN: There is no motion on the floor. If there is a motion made, I think we can discuss it.

Will you read Dr. Montgomery's reply before we vote? Isn't that fair?

THE SPEAKER: Dr. Montgomery has no reply. This is simply his credentials from the Secretary of his County Society.

DR. CHRISTIAN: It may be out of order, but it seems to me this is very irregular. If you are asking the House to decide on the competence of this man to be seated, we ought to hear him. We ought to know what these charges are. We have only heard a little. I know nothing about it, but it seems to me it is a little bit out of order.

THE SPEAKER: May I explain that? We haven't the time to go into long discussions. Now, you have heard the explanation. There is trouble up there and it was presented by the Ethics Committee and it, after a thorough investigation, recommends that this society is not in good standing and that has been sustained by the MSMS Council. Now, it is a question of whether this man is to be seated. It is a question of whether the House of Delegates wants to seat him or not. I think it is a question of yes or no, at this time.

DR. CHRISTIAN: Again may I say, the Council has all the evidence. We have none. Why doesn't the Council decide? We have no evidence. This is a serious thing. You are voting out ten, twenty, or forty members.

THE SPEAKER: Dr. Christian, you don't understand. You didn't listen. This question being decided tonight is only a question of whether or not to seat Dr. Montgomery in the interim. The other question will not be discussed until tomorrow night as I told you. The detail will be entirely different. This is merely a question of whether or not to give Dr. Montgomery the privilege of being seated.

DR. CHRISTIAN: May I rise to a point of order, then? May I ask the Secretary to read the question of who shall be seated in this House and when he shall be seated?

THE SPEAKER: It is left to the Credentials Committee and the Credentials Committee does not want to take the responsibility without the consent of the House.

DR. CHRISTIAN: May I request the Credentials Committee to come forward? I want to ask them a question.

THE SPEAKER: You can ask them a question if you want to. I think I can answer the question.

DR. CHRISTIAN: I want the Chairman of the Credentials Committee. I know nothing about the controversy, but I want to see this done right. This is a serious charge. The county medical society has sent their delegate here.

R. L. NOVY, M.D. (Detroit): There still is a Chippewa Society, isn't there, at the present time?

THE SPEAKER: It is not recognized.

DR. NOVY: There is a County Society unless the House does not recognize it?

THE SPEAKER: It is merely a question of seating the delegate.

Section 4. "The officers of county societies shall certify to the State Secretary the names of the delegates and alternates who shall represent them at the Annual Meeting."

Now then, there has been very good reason to believe, Dr. Christian, after thorough study by our Ethics Committee, that there were irregularities in the meeting up there.

DR. CHRISTIAN: Please understand me. I merely want to bring it before the floor of the House to see what the things are.

THE SPEAKER: Then, the Chairman will entertain a motion to seat the delegate.

DR. CHRISTIAN: I move that the delegate from Chippewa County be referred to a special committee of this House to report tomorrow morning.

THE SPEAKER: The Chair doesn't wish to accept that motion. He asked for a motion to seat the delegate. We can't discuss other things.

DR. CHRISTIAN: I can't do that because the information is not forthcoming. Again may I say to the delegates that I know nothing about this, but I do not believe any county medical society should be denied a voice on this floor unless we know about it, and I have asked for the Chairman of the Credentials Committee for the cause. With that, I will sit down.

S. L. LOUPEE, M.D. (Cass): Did not the Secretary state that this whole matter would be brought before the House of Delegates tomorrow evening?

THE SPEAKER: That is correct.

DR. LOUPEE: Does this motion provide we shall vote to settle the seating of the delegate from Chippewa temporarily until tomorrow evening or permanently?

THE SPEAKER: I think it would have to be permanently for this meeting.

DR. LOUPEE: How are we going to vote to seat him permanently until we know the action of this group tomorrow evening?

THE SPEAKER: Until the group has taken action, I will accept that motion. The Chairman will accept the motion to seat the delegate from Chippewa County until such time as the House of Delegates has passed sentence.

R. L. WADE, M.D. (Branch): Suppose you find that this society is guilty of some misdemeanor and that we would not approve of their actions? Then, we would have to expel this member whom we elect tonight. That is not fair.

THE SPEAKER: Not necessarily. You don't have to take any action on that. The only question before the House is, Whether or not to seat this delegate until such time as the House determines what to do with the County Society. That is all there is to it.

T. K. GRUBER, M.D. (Wayne): May I ask if the Charter of this Society has been revoked by the Council?

THE SPEAKER: Oh no, the Council hasn't the authority to revoke that.

Just a moment. Let me tell you what has been done. The Council has petitioned the House of Delegates to revoke the charter and we cannot take action on that at this time because there are too many things coming up first. We would have our whole meeting spent on it.

DR. GRUBER: In reading Section 6, pages 95 and 96, it says, "It shall upon application provide and issue charters to county societies organized in conformity with this Constitution and By-laws and revoke such charters when deemed necessary." There is no reference to the House of Delegates at all.

THE SPEAKER: If you will look on page 87, Chapter 1, Section 2 of the By-laws you will see that the method the Council has of doing that is by recommending it through the House of Delegates.

DR. GRUBER: From reading the two, I think it would be well if the By-laws—the two sections—were brought into conformity. One says the House of Delegates shall, and the other says the Council shall.

THE SPEAKER: You are out of order for the time being. Are you ready for the question?

(The question was called for.)

THE SPEAKER: All in favor of having Dr. Montgomery seated until such time as the House shall determine the status of his society, say "aye"; contrary "no." Dr. Montgomery is seated and will the Credentials Committee see he has the proper introduction?

S. L. LOUPEE, M.D.: Since this matter is up for discussion, I would like to know whether any special study is going to be made of that very important question between now and tomorrow evening.

THE SPEAKER: That has been disposed of and we will go on with the regular order of business. I will answer your question later.

The next thing is the appointment of committees. First, we will appoint the Press Committee. We are glad at this time to welcome the members of the press. The members of the press have been very kind to us in the past and we ask the same co-operation of them this year as they have given before, which is a definite request that they are not to publish anything unless it has gone through our Press Committee.

The Press Committee: Harry H. Dibble, M.D., Chairman, E. A. Oakes, M.D., L. F. Foster, M.D.

Now, the other committees will stand as on page 3 of your Handbook, with these exceptions: H. E. Hanson, M.D., on the Committee of Officers Reports, is not here. He will be replaced by B. G. Holtom, M.D., of Calhoun County. That is the same county.

W. E. Nesbitt, M.D., under Reports of Standing Committees, is not here. He will be replaced by F. J. O'Donnell, M.D., Alpena.

The committees will meet directly after the session tonight. They are meeting tonight in the rooms listed on the blackboard. The stenographers for these committees will be in the room directly in back of this one. Please do not ask them to go to other rooms to take work. They will be here tonight and tomorrow night, and will take care of anything you might have to do.

Now, Dr. Loupee, may I answer your question briefly? I thought I had explained that before, but I will explain it once more, because this is a very serious and delicate matter and I assure you, as far as the Speaker of the House of Delegates is concerned, these gentlemen will have the fairest kind of treatment. What we propose to do is this:

This will be handled, according to that section which we have already invited to your attention, but when this is taken up tomorrow night, all of this material will be reviewed. If, at the end of that review, and if after answering as many of your questions as we can, you are ready to take action on the problem, and think it has had sufficient study and are willing to take action on it at that time, you will be asked to vote. If the majority of the House of Delegates feel we are not ready to take action on it at that time, action will be delayed for a future meeting.

Does everybody understand that now? Do you agree that it is fair to those who are in trouble? That is the way we intend to handle it. Does that answer your question?

DR. LOUPEE: I want to commend you for ruling me out of order and proceeding with the business.

THE SPEAKER: Thank you.

The next order of business is the Speaker's address. The Vice Speaker will please take the Chair.

(E. A. Oakes, M.D., the Vice Speaker, assumed the Chair.)

THE CHAIRMAN: Mr. Speaker, I would like to say a few words, particularly to the newer delegates who haven't been seated in the House of Delegates before. The Speaker's address sets the keynote and tells us what we have to do, not only here in the House of Delegates, but largely what is planned for you. I commend your very active interest because Dr. Ledwidge always has something on the ball and he has something that is important to each one of us. I present the Speaker!

II. Speaker's Address

The Speaker's Address will be confined to a progress report on the Emergency Maternity Infant Care Program in Michigan.

The Michigan State Medical Society House of Delegates, on Sept. 21, 1943, passed two motions on this subject as follows:

(1) "Because this plan is a form of state medicine, the Michigan State Medical Society refuses to cooperate in any of the provisions of the plan in the present form."

(2) "Until satisfactory adjustments in the plan can be made the members of the Michigan State Medical Society are requested to give medical care gratis, in order that the wives and children of servicemen may obtain hospital care."

Pursuant to the instruction implied in this second motion the Council, through its special EMIC Committee (Drs. Keyport, Foster, and Ledwidge) has continued to negotiate, but has accomplished little. In the process of these negotiations meetings have been held with the Auditor General of Michigan, with Michigan Medical Service, with the Michigan Department of Health, and two meetings with representatives of the U.S. Children's Bureau. The first of these two meetings was with Edmund F. Daily, M.D., of the Bureau, when he appeared before the full council, September 23, 1943; and the last was with Martha M. Eliot, M. D., Assistant Chief of the Children's Bureau and Peter Seitz of the Solicitor's Office attached to the Bureau, June 8, 1944.

By February it became fairly evident that "satisfactory adjustments" were not to be made, and under instruction of the Executive Committee of the Council the "Secretary's Letter" carried the following advice to our loyal members: "So far as the State Medical Society is concerned, physicians may properly:

(A) Sign the blanks to provide for hospital service, giving professional care gratis; or

(B) Sign the blanks and accept the government fee for medical care; or

(C) Decline to participate in the program, as they see fit."

Three requests for major changes in the method of administration of the program have been made. All three have been refused by the United States Children's Bureau.

Request number one was that recipients of service under the program, who so desire, might have their hospital expense paid and be permitted to obtain medical care from their own private physicians on a fee basis. You will recall that this request was rejected by a telegram to Dr. Moyer which was read to this body during our 1943 session.

The second request, namely, that allotments for the EMIC program be made direct to the serviceman's wife and dependents, is one that has been made by the American Medical Association House of Delegates, by several state medical societies, and by other professional groups. It has been turned down on the grounds that it is contrary to the intent of Congress and therefore cannot be put into effect without congressional action. Just how far the intent of Congress has been influenced by the Children's Bureau is difficult to ascertain. The facts seem to be these. The trial balloon for the EMIC program was carried out in the State of Washington in 1942. In this project the Chief of the Children's Bureau used funds that were then available to her department and certainly had complete descretionary power. From March, 1943, to September, 1943, inclusive, Congress passed three separate bills appropriating funds for the EMIC program. None of these bills specifically states how the money shall be paid, and it is reasonable to assume that in the beginning considerable descretionary power in this regard was left with the Chief of the Children's Bureau. At any rate the program calling for payment direct to physicians was set up, as you know. Congress, in making its second EMIC appropriation in July, 1943, did not criticize this method of payment, which was interpreted by the Bureau as approval. When the third appropriation bill was before Congress in September, 1943, an amendment calling for allotment was offered and was defeated in the House of Representatives. Hence, the conclusion that congressional action would be required to make the change at this time seems justified, but the responsibility of the Chief of the Children's Bureau in thus setting up the program cannot be denied.

That Doctors of Medicine in this state, who so desire, be paid through Michigan Medical Service was the third request. This possibility was first discussed September 23, 1943, with Dr. Edmund F. Daily of the Children's Bureau, who invited us to submit a plan. The Michigan State Medical Society membership was polled on this matter in October, and those who answered expressed a preference for payment through Michigan Medical Service by a vote of six to one. A plan was then worked out but was rejected by the Children's Bureau in February. Having the approval of Michigan State Medical -Society, Michigan Medical Service, Michigan Department of Health, and the Auditor General of Michigan, the plan, with certain refinements, was resubmitted through the Assistant Chief of the Children's Bureau at our June 8 meeting. Notice of its second rejection was given by telegram from the Chief of the Children's Bureau to William DeKleine, M.D., Michigan Commissioner of Health, under date of September 14, 1944. The reason previously given for its rejection was that the Solicitor could find no precedent for assigning a federal administrative duty to a private agency. This seemed to us a silly ruling in view of the fact that Michigan Medical Service is a nonprofit service organization, and especially in view of the fact that the whole EMIC program had been set up without precedent. This latter ruling is not a matter of great importance except as it reflects the attitude of the Children's Bureau to the Medical profession. This attitude is reminiscent of, and perhaps best exemplified by a notice once seen posted in a service garage which read, "Please do not be afraid to ask for credit, our refusal will be courteous." Suggestions from our group are solicited but usually are not followed by the Bureau.

The Bureau has made some concessions that directly affect our membership. I shall enumerate them:

1. The Medical Advisory Committee to the Chief of the Children's Bureau has been enlarged to include five general practitioners. The members of this committee are invited by the U. S. Secretary of Labor and are called together from time to time by the Chief of the Children's Bureau to act in an advisory capacity only. It has previously been made up of specialists, teachers, and institutional men, many of whom are not engaged in the practice of medicine.

2. As of February 1, 1944, the fee schedule in Michigan was increased.

3. Our suggestion as to the method of selecting consultants in the program apparently has been accepted. This insures each of our members the right to qualify

as a consultant and makes him eligible to receive the consultation fee if and when he is called as a consultant.

The following data relevant to the EMIC program are interesting:

1. The case load in Michigan is averaging from 1,000 to 1,800 per month. The highest figures were reached in June, July and August of this year. The total number of applications up to September first was 19,742, of which 1,302 were pediatric.

2. Now co-operating in the Michigan plan are 1,988 Doctors of Medicine and 344 osteopaths. Under a Children's Bureau ruling the osteopaths are limited to obstetric care only. The 3444 osteopaths have made 1,276 maternity applications.

3. Effective February 1, 1944, a new schedule of fees was established as follows: Up to $15.00 for prenatal care, $35.00 for delivery with six weeks subsequent care of mother and two weeks care of infant, and $5.00 for postpartem examination six weeks after delivery; for pediatric care $3.00 per house call and $2.00 per office call limited to a total of $24.00 without further authorization; for consultation a maximum fee of $10.00 is allowed.

4. Hospitals are now paid fees to cover their individual per diem cost.

5. As of June 1, 1944, the over-all EMIC federal case load was running about 40,000 per month.

6. There was available for this program for the fiscal year ending June 30, 1944, $29,700,000. For the fiscal year beginning July 1, 1944, Congress has appropriated $42,800,000 of which not more than 2 per cent may be used for administrative purposes.

The EMIC program has not been a total loss to our Society. It has demonstrated once more that the Doctor of Medicine in private practice recognizes and accepts his responsibilities and will take care of his people even though the going is tough and the circumstances distasteful. In the last analysis it has served to create a beter understanding between the Michigan State Medical Society and the Michigan Department of Health. Our dealings with that department in the past year have been most cordial. Lastly, it has taught us, or should have taught us, something of the fallacies of federalized medicine in general, and of its administration by the U. S. Children's Bureau in particular. In this connection we have been assured that the EMIC program is in truth an emergency measure that will terminate six months after the war's end, but we have very good reason to suspect that further legislation along similar lines is in the offing.

Two statements by Martha M. Eliot, M.D., Assistant Chief of the Children's Bureau are pertinent. When in conversation with Dr. Eliot, Dr. W. W. Bauer of the American Medical Association remarked: "The doctors would be better satisfied to co-operate in this plan if they could be assured that it is not the opening wedge for broader plans." Dr. Eliot is said to have replied, "I dont' think they can be given any such assurance." At our June 8 meeting the question of the possibility of the EMIC being extended into the postwar period was raised. Dr. Eliot stated that this program was authorized by special emergency legislation and would not be extended into the postwar period. Then added, "Any future legislation will have to be very carefully written." While Dr. Eliot is to be commended for her forthright frankness, the implication as to future legislation is clear.

Well, what should we do about it. Your Speaker does not pretend to know the answer, but respectfully submits these suggestions for your consideration:

1. That for the present we continue with each individual Doctor of Medicine exercising his right to accept the government fee, to take care of the serviceman's wife and dependent gratis, or to decline to participate in this program as he sees fit.

2. That we, individually and as a group, help the U. S. Children's Bureau to keep its promise to terminate the EMIC program six months after the end of the present war, by not co-operating in the program after that date; and, that this expiration date be called to the attention of our membership through the then current "Secretary's Letter."

3. That in keeping with the "Declaration of Medical Policies" adopted by this House of Delegates last year, we flatly refuse to participate in any future health program that is inaugurated without first having been submitted to our Society for study and approval.

4. That if and when such plans are submitted to us for study, we study them with a tolerance and fairness becoming to our profession.

THE CHAIRMAN: Thank you, Dr. Ledwidge. The Speaker's address will be referred to the Committee on Officers' Reports. I will turn the Chair back to the Speaker.

(The Speaker reassumed the Chair.)

THE SPEAKER: Our next order of business is the President's address by President C. R. Keyport, M.D.

III. President's Address

One year ago, when I was inducted into the office of president of this association, I said, "To serve as president of the MSMS is a distinct honor. It is with genuine appreciation of this privilege and responsibility that I pledge my efforts to maintain our program of democratic medicine and to urge that your participation and co-operation be steady and enduring."

During this past year, I have enjoyed the highest honor which the Michigan State Medical Society can bestow, the presidency of this organization. I have watched with great interest, the growth of united solidarity in our profession. I have been deeply impressed by the willingness and sincerity of fellow workers who shouldered responsibility and gave me competent aid in the administration of this society. I shall never cease to be profoundly grateful for the distinct values which have accrued to me through this generous and loyal association. I feel that the MSMS as an organization is one of the finest examples of an unbiased and co-operative group that can be found any place in the world.

It is understandable, however, during the past year that some of you may have felt my leadership has over-stressed the economic side of medicine. Through THE JOURNAL, I have insistently called attention to the economic problems of medicine. In nearly every issue, I have emphasized solutions needed and have laid particular stress upon immediate action in that direction.

These are times of national unrest and world conflict. If we are going to preserve our democratic principles, particularly in reference to giving the people of this state and these United States the finest medical service in the world, making it available to all the people, then, I feel we must do so by considering the economic side of medicine.

I regret that each and every one of you cannot be a member of the Council or the Executive Committee of the Council. It is a revelation to sit in these meetings and see the careful, thoughtful deliberations of these men. The chairman of the Council has a tremendous amount of work to do, and Dr. Vernor M. Moore deserves a sincere vote of appreciation from this House of Delegates.

In Dr. L. Fernald Foster as secretary, and Bill Burns as executive secretary, MSMS can boast of the best secretarial combination of any society in these United States.

Dr. Wilfrid Haughey and his publications committee of the Council have been responsible for THE JOURNAL,

and each and every one of you can attest to the excellence of this publication and be justly proud of it.

As long as Dr. William A. Hyland is treasurer of this Society, you can rest assured that financially MSMS has nothing to worry about.

To the various committees of the State Society, I can only say that you have been grand during this past year, and the many accomplishments mark additional pages of fine achievement in the history of the Michigan State Medical Society.

During the past year, we have had numerous problems to consider. You will recall that during the meeting of the House of Delegates last year, we were most concerned with the EMIC Program, and this body, the House of Delegates, referred the matter to the Council. The Council then referred this matter to a special committee of which Dr. Ledwidge was chairman. Many meetings of this committee were held with State and Federal agencies, and regardless of the untiring efforts of Dr. Ledwidge and his committee, there has been no change in the administration of this program. Let us hope that in the immediate future, we will be better able to combat this vicious type of federal legislation in its inception, and curb the autocratic rule of bureaucrats who seemingly are not responsible to any legislative controls.

During the meeting of the Council in July of 1943, there was formed the Michigan Health Council. The groups comprising the Michigan Health Council were the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service and Michigan Hospital Service. This council was created to act as a clearing house for all four organizations on matters of mutual interest, so as to keep all organizations informed of the program and actions of the others, to enable all the organizations to present a united front on matters of common interest and to prevent conflicts which might affect two or more of these organizations.

This Michigan Health Council was a little slow in getting started but it is now well established and the recent economic survey made in Michigan under the direction of the Michigan Health Council will be presented to you during this meeting. I am confident this survey will be of real value to each and every one of you.

One of the undertakings of the Michigan State Medical Society in the past few years, and the one that has caused many headaches, and also many personal controversies, has been our own program of providing a means whereby the people of Michigan could obtain adequate medical care. This program envisions medical care geared to the economic status of the people, and makes provision for budgeting against catastrophic illness. I speak of Michigan Medical Service. I am happy today to announce that Michigan Medical Service is rapidly becoming solvent; it is meeting a much-needed demand and is going to continue to advance and bring added benefits to its policyholders. All this is a glowing tribute to the officers, the board of directors and the individual doctors of the State of Michigan.

During the past year I have continually stressed the necessity of the economic side of medicine and the need for better controlled and integrated public relations. In the past we have been too prone to delegate all matters dealing with legislation as they affect us to our legislative committee. The legislative committee is composed of Doctors of Medicine. They are not legislators or politicians. They are too much engrossed in the practice of medicine to devote much of their time to matters of legislation. It should not be expected or requested of medical men.

What we need is a full-time public relations man. There is no more important group in this state than the doctors. If the public utilities, the railroads, the chain stores and a host of other groups can have a full-time public relations man why not the medical profession?

What I mean by a public relations man is not an individual who plays around our State Capitol trying at the last minute to block some bill which we think is bad for medicine and public health; but a public relations man who can during the entire year so carry on a program of public relations in every representative district so that when legislative acts are proposed which tend to lower health standards or are going to change the picture of the practice of medicine as we know it we will not be caught with our fences down.

For example, at this very moment there has been prepared one of the most drastic proposals in the shape of an amendmment to the constitution of the State of Michigan. If the people vote favorably for such an amendment it would make the Murray-Wagner-Dingell Bill look like small peanuts in this state.

Fully confident of your approval I can now disclose to you that at the midsummer meeting of the Council the Executive Committee was authorized to proceed to employ a public relations man. A committee is at present endeavoring to find the best possible man in Michigan for this most important job, and when he is secured, he should not be an undercover man, but should be definitely known as the public relations representative of the physicians of Michigan.

Last year, this House of Delegates voted an assessment of $10.00 per member to carry on an educational program. During this meeting you will be appraised of the monies expended for this work. While there may be a balance on hand, the whole amount has been allocated; I sincerely hope that this House of Delegates will vote to continue this assessment this coming year and for as many years as future needs demand. You need to protect yourselves during this critical era.

Through the generosity of the late Andrew S. Biddle, who at the time of his death was our oldest Past President, the Michigan State Medical Society Foundation for Postgraduate Medical Education has been further endowed. This marks the beginning of a *live* endowment fund. The noble example of Dr. Biddle should be followed by many other doctors of medicine who have been privileged to reap the rewards of a grand profession. The opportunity and privilege of contributing to the Foundation for Postgraduate Medical Education is yours, now.

As I relinquish the presidency of this Society to the president-elect, Dr. Andrew S. Brunk, I hope that your unlimited support will continue during his administration. Your unfaltering loyalty and alert cognizance of forward procedures in the years to come will enable the MSMS to continue to hold the respect of the people of this state, and at the same time, to administer the best medical services in the world to the people of Michigan.

THE SPEAKER: This report will be referred to the Committee on Officers' Reports.

I wish now to make one announcement which I should have made earlier. There is one change in reference to the committees. On the Reports of Special Committees, W. H. Honor, M.D. (Wayne), who has not been well for the last few days, will be replaced by Frank A. Weiser, M.D., also of Wayne County.

It is a pleasure now to call on our President-Elect, Andrew S. Brunk, M.D.

IV. President-Elect's Address

Principles worth while must be fought for, to be preserved. Today we are fighting a World War to uphold and maintain a great principle: freedom under democracy. It is a costly fight, bringing sorrow and misery, but it is a worthy one. When the battle ends and victory is ours, a great principle shall have been preserved to us but especially to our posterity.

During the stresses of this wartime period strong winds of social change are blowing. Straws in that wind would indicate that Medicine will not be untouched in the evolutionary metamorphosis resulting from the

present global struggle. We might mention but three of these many straws to illustrate: (a) the Wagner-Murray-Dingell Bill, (b) the autocratic rule of the U. S. Children's Bureau in the EMIC Program, (c) the proposed "State Medicine" amendment to Michigan's Constitution.

Medicine has great principles, developed throughout the years, in the interests of those whom we serve, our patients. Under these principles Medicine in these United States has achieved the highest scientific attainments in the world. The best medical care anywhere at any time is attainable in this country under the present system of time-tried, private medical practice. Some Utopian sociologists, aided by some very practical politicians in this country, would change these principles upon which Medicine is founded—in fact they would throw away all vestige of the present principles and substitute in their stead the dictum of compulsory rule which experience has shown would lower the present high standards. Despite their greatness in numbers and power these enemies of a great science must be stopped. The great principles behind medicine must be fought for to be preserved. A practical plan must be outlined to show the people what they will lose if they listen to the false chant of certain politicians and sociologists (including unfortunately a number of our own brothers) who have much to gain personally from public acceptance of their ideaology.

It is time for us doctors to awake, and know what is going on about us. Realize the attacks being made upon us and our profession. They are real. They are powerful.

You delegates from every county medical society of Michigan are the natural leaders in your communities. Aided by the officers of your county societies, you must spread your knowledge to every Doctor of Medicine in your organization. He in turn must tell the people the facts—the truth. It is the people who will decide the issue, and SOON. There is no time to lose. Our principles are being attacked today; if we would maintain a great principle—medical freedom under democracy—we must join the fight now. It may prove to be a costly fight, but, Gentlemen, it will be a worthy one. We shall be fighting for a great principle which shall have been preserved not alone to us but to those who follow us in Medicine.

Therefore, during my brief tenure of office, I pledge that I shall support enthusiastically an acceleration of a program of greater information to the people. The history and accomplishments of Medicine must be told. The work that Doctors of Medicine are doing—both at home and in military service—must be stressed. Our citizens must be impressed with this truism: that only a free science, unchained and untrammeled, can soar to greater heights.

Further, I pledge that every effort will be made to bring proper information to those men and women who make the laws affecting you and your practice, to the end that health legislation, which in Michigan has been of high type in recent years, is not tampered with or destroyed.

Third, with the help and approval of the practitioners of Michigan, that facilities and programs supplemental to medical practice, will be instituted or maintained where necessary. As an example, Michigan Medical Service, our group medical care plan, must be mentioned with pride. This your-year old supplement to medical practice has proved to be a successful experiment—the best in the country—and a bulwark against threats of federalized and state schemes of compulsory medical practice. With its flaws, Michigan Medical Service is to be preferred to some nebulous scheme of dreamers or schemers. Michigan Medical Service supplements, in a fiscal manner, medical practice. It is not a substitute. It does not change the principles of Medicine. I repeat, Gentlemen, it is to be preferred, because it is our plan.

Fourth, I pledge that every effort will be made to enlist the support of other persons, groups and organizations, that will aid Medicine to preserve its principles. Specifically, let me mention one organization which had its beginning as recent as July, 1943; The Michigan Health Council. This association of representatives of the Michigan Hospital Association, Michigan Hospital Service, Michigan Medical Service, and the Michigan State Medical Society, is a vehicle whereby these organizations can co-ordinate their efforts in arranging for the availability of medical, hospital and related services, and informing the public through a general educational program what these organizations are doing to meet the health needs of all people in the state. The program of The Council will be based upon facts gathered from the people themselves through a survey of public opinion—the premier release of this poll to be presented in this room, next Thursday evening, September 28, at the evening General Assembly. The Michigan Health Council should be a great force for good in this state. Its information to the public will be based on facts, without bias. This Council and all similar organizations must be told of the attack on Medicine, and their co-operation must be enlisted to help in our fight. They *must* help us, because their interest is the people's interest, and our battle to preserve Medicine's principles is also in the people's interest.

Let me conclude by thanking all of you, for the whole hearted co-operation, which I am sure I will receive. I need your support to make the 1944-45 program a success.

THE SPEAKER: The President-Elect's address will be referred to the Committee on Officers' Reports.

V. W. Moore, M.D., Chairman of the Council will present the Annual Report of the Council at this time.

V. Annual Report of the Council

SUPPLEMENTAL REPORT OF THE COUNCIL, MSMS

September 25, 1944

The Annual Report of The Council for the year 1943-44 appears in the Delegates' Handbook beginning at page 34. As this report was written in July in order that it might appear in print, The Council wishes to submit additional information on matters which it has considered during the past two months:

1. *Revision of By-laws.*—The Council referred two proposed revisions of the By-laws to its Special Committee on Constitution and By-laws, C. L. Hess, M.D., Chairman. This committee considered amendments re (a) special membership for members incapacitated due to military service, and (b) ethics, and reported to The Council in July. The Council, after studying the proposals for a considerable length of time, received the first amendment and referred it to the 1944 House of Delegates; it re-referred the proposed Ethics Committee amendments back to the Special Committee which again reported on this matter to the Executive Committee of The Council on August 24. The Executive Committee received the final report and requested the Special Committee to present its recommendations to the House of Delegates on Septembr 25, 1944.

2. *Declaration of Medical Policies.*—In September, a second printing of the "Declaration," together with a Pledge to be signed by every MSMS member, was mailed to the entire membership. The Council of the State Society needs the tangible support and "backing" of every member of the Michigan medical profession. A return of 4,000 or more Pledges will represent vast support and show the strength and unity which exists in the ranks of the medical practitioners in this State. The total number of Pledges signed and returned to the Society, by September 22, were 1,005.

3. *"We Need a Book."*—A treatise containing Facts and Fancies about Medicine, for public consumption, is vitally needed. The Council appointed a Special Com-

mittee which reported that a permanent, attractive book should be prepared, well illustrated and written by a professional author who obtains his facts from the Michigan State Medical Society and other organizations involved; further that this book should be thoroughly distributed to the public, but be of such a format that it is salable. The preparation of such a book is now being considered.

4. *Proposed amendment to Constitution of Michigan.*—A petition proposing an amendment to the Constitution of the State of Michigan, *which would include a system of compulsory sickness insurance,* was presented to the Michigan Secretary of State in June, 1944. A committee of the State Medical Society has been appointed to work out a detailed program so that information concerning the weaknesses of such a revolutionary proposal can be brought to the people, should this proposal be placed before the people for their vote next spring. If such a monstrosity *is* presented, it will require the concerted and sustained efforts of every individual member of the medical profession to help defeat this scheme which outdoes the Wagner-Murray-Dingell proposal. If sufficient signatures are presented to the Secretary of State, the medical profession of Michigan *can look forward* to the most bitter, time-consuming, and costly battle of—and for—its present existence.

5. *Public Relations Activity.*—A full-time public relations counsel and a permanent, sustained program of information, first, to the profession and, second to the people is necessary *now.* Every member of the profession must know what social, economic and political issues are facing him: and more important, what are his responsibilities in solving these problems. County medical societies and their individual members must enlist support back home—the most powerful contacts being in the doctor's own home town. The stimulus for this necessary, vital public relations program will come from the full-time services of a man trained in public relations work. The Council has voted to employ such a specialist and to create this new department.

6. *Public Education Account.*—This fund, accumulated from the special $10.00 assessment levied by the 1943 House of Delegates, has been kept separate from the other funds and accounts of the Society and has been used exclusively for public educational purposes, as indicated by the following accounting (up to September 22):

PUBLIC EDUCATION FUND
FINANCIAL REPORT
To September 22, 1944

School of Information (1/30/44)	$ 3,059.71
Purchase of Pamphlets	1,329.92
Michigan Health Council	5,000.00
Radio Program	10,001.80
Publicizing Radio Program	500.17
Miscellaneous	9.70
	$19,901.30

The unspent balance is already allocated for the same and similar public education activities.

Concerning the *ordinary* funds of the State Society: the remission of dues of 1,151 members now in military service has meant a loss in annual revenue of over $11,000. Despite this shrinkage of income, the activities of the Society have not been curtailed; in fact, the threat of the Wagner-Murray-Dingell Bill, the proposed amendment to the Constitution of Michigan, and similar revolutionary proposals have forced added work on the State Society and its Executive Office, as has been the experience of every other live state medical society (with which we are in constant touch and working in harmony). We may be forced to draw upon our reserves to a limited extent, but due to the good business management of the Society, this will not be great.

7. *Michigan Health Council.*—The sponsors of the Michigan Health Council, as will be remembered, are the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service, and Michigan Hospital Service. The first two organizations are represented on the Health Council by three members each; the two pre-payment plans each have representation by two members.

Thus far, the Health Council has been supported financially by contributions of $5,000 each from the Michigan State Medical Society and Michigan Medical Service, with an equal amount from the two hospital organizations. Total contributions thus amount to $20,000. Of this amount, some $9,000 is set aside as the expense of the survey of public opinion, and disbursements have amounted to $3,038.63 as of September 12. Slightly more than half of the disbursements have covered fees and travel expenses connected with public addresses sponsored by the Health Council and the balance has gone into salaries, office rent, and incidental expenses. The unexpended balance on September 12, 1944, amounted to $7,842.91.

What the Michigan Health Council has sought is a constructive program of mutual benefit to the medical profession, the hospitals and the public. We feel that the projects we have undertaken to date should be of definite help toward the realization of that program.

8. *Problem of Ethics.*—The Ethics Committee report (page 48 of the Delegates' Handbook) indicates that it has had its troubles with one county medical society during the past year. The long-standing problem at the Soo finally resulted in a meeting ordered by The Council on September 8, and to be presided over by the Councilor of the 12th District, MSMS. No quorum was present.

A petition on this subject will be presented to the House of Delegates at this meeting.

9. *Brasie Resolution of 1943.*—A Special Committee (Sladek, Beck, Riley, Witwer) was appointed by The Council to study and report on this proposal to limit Michigan Medical Service to Doctors of Medicine.

If this Resolution were adopted, it would put Michigan Medical Service out of business. Michigan's successful program of group medical care cannot survive if such peremptory action is taken at this time. (The problem outlined in the Resolution was not created by Michigan Medical Service); it represents an ever-increasing growth over the years that is a *problem of Medicine, for the profession to solve.*) If you desire Michigan Medical Service, which is our only telling answer to federalization and regimentation, to continue as your bulwark, this Resolution should be tabled and in its place specific authority to test the legal rights of certain practitioners—the *test to be timed for the most propitious moment—should be granted The Council.*

10. *Bequest of the Biddles.*—The Late Dr. and Mrs. A. P. Biddle have remembered in a most generous way the Michigan State Medical Society. At the doctor's death (August 2, 1944) the Society was informed that proceeds from insurance policies, in the amount of approximately $15,725.00 and an additional $5,000 from the residue of Dr. Biddle's estate, were immediately payable to the MSMS Council, and that the Society also was a legatee (subject to a life interest, of the residue of the Grace W. Biddle Estate in the amount of approximately $21,000. In all, the total amount left to the MSMS by Dr. and Mrs. Biddle will approximate $42,000.

Several years ago, The Council created the Michigan State Medical Society Foundation for Postgraduate Medical Education and placed the first sum ($10,000) in this fund. Dr. Biddle's great contribution justifies the foresight of The Council. His extreme generosity should serve as a noble example that could be followed by other Doctors of Medicine and laymen interested in continuing medical education.

THE SPEAKER: This report of Dr. Moore's will be referred to the Reference Committee on Reports of the Council.

THE SPEAKER: Now, going on with the regular order of business, the Report of the House of Delegates of A.M.A., by Henry A. Luce, M.D.

VI. Report of Delegates to A.M.A.

HENRY A. LUCE, M.D.: If you will turn to page 44 of your Handbook, I will read the first paragraph:

"The regular delegates from Michigan were all present and took an active part in the proceedings of the 94th Annual Session of the American Medical Association held in Chicago, June 12 to 16, 1944. There are many delegates from other states who either are indifferent or take little interest in crucial matters affecting the organization. Many are out-and-out specialists and only manifest interest when their 'ox is gored.' Many have secured economic independence and have little interest in the general subject of economics as it affects the man in the 'sticks.' Others enjoy a ride on the bandwagon and, like puppets, perform when the 'old guard' pulls the string."

I have said once before that I have felt, and that it is my opinion, that there is more real knowledge of medical economics represented in the House of Delegates of the Michigan State Medical Society than there is in the American Medical Association's House of Delegates. There are many good men in the American Medical Association's House of Delegates, but there are a great many of them who fall into the classifications which I have just read to you.

The American Medical Association has done a great many commendable things. A great deal of scientific knowledge has been fostered. A great many projects of scientific nature have been nourished and nurtured, but to most of the men who practice medicine, they have felt that the House of Delegates or the Board of Trustees or the Officers of the American Medical Association have not been close enough to their problems. I will speak a little more of that later.

The resolution that was referred to the delegates from Michigan to be presented regarding the change of the American Medical Association from a scientific body into, as you might call it, a business league, was presented by Dr. Gruber and I want to give you a little more information on that later.

On page 46, you will notice two or three minor resolutions that were passed. The attitude of the profession regarding maternal and infant care, a resolution to transfer those activities of the Children's Bureau to the Public Health Service, was approved. On the other hand, a resolution to consolidate federal health activity in a single federal health department was disapproved. Very frequently, the House of Delegates will approve one thing and disapprove a similar thing.

Probably the most interesting point in the whole meeting was the report on a resolution that came from the state of California.

This is what is published in J.A.M.A.: "Dr. Dwight L. Wilbur of California presented by title, a resolution dealing with the Secretary of the American Medical Association which was referred to the Reference Committee in Executive Session."

Now, that reference committee made its report on the resolution concerning the Secretary of the American Medical Association, referred to it by title, something like this: Never before has American Medicine been so needful, as now, of unity. The desire to extend the high quality of medical service to all the people at a reasonable cost is the objective sought by all of us. Your committee is convinced this can be attained more certainly if physicians throughout the nation would give their loyalty and support to those selected by this House of Delegates as members of the House of Trustees and to the representatives selected by the Board itself.

The Reference Committee did not approve this resolution from the State of California.

In other words, the committee disapproved that resolution.

Before it went to ballot or before they asked to vote on it, the minutes carry the following statement:

"A vote by ballot was requested by Henry A. Luce, M.D., of Michigan, seconded by Walter B. Martin, M.D., of Virginia." This motion was laid on the table, so only nine registered a vote in favor of the California resolution.

I have asked the other members who are Dr. Christian, Dr. Gruber, Dr. Keyport, Dr. Reeder, to give you something further as a report. I will ask Dr. Keyport to give you something about the Wheeler Bill. I will ask Dr. Gruber to give you something about national activity and what provisions have been made for returning medical officers. I will ask Dr. Reeder to tell what other states are doing in regard to the maternal emergency care, and they will give that tomorrow as a supplemental report.

Now, Mr. Speaker, if you will call upon the other members of the delegation I shall conclude my report as chairman of the delegation.

THE SPEAKER: Thank you. Dr. Luce's report will be referred to the Committee on Officers' Reports.

VII. New Business

THE SPEAKER: It is now our privilege and pleasure to introduce one whom I shall call a friend. He is Ira Dean of Grand Rapids, president of the State Association of Welfare Boards.

VII—2. ADDRESS OF IRA DEAN

Mr. Speaker and Members of the Board of Delegates: I am more than pleased to be here tonight for two reasons: One is that we are happy to have you meet here in Grand Rapids, which we consider one of the best convention cities in the State of Michigan, and on behalf of the State Association of County Social Welfare Boards, I wish to thank you for the privilege of appearing before you and assuring you that we appreciate your co-operation and that of the County Medical Associations.

This legislation which returned the administration of relief back to the counties where it rightfully belongs, started operating on December 1, 1939. I could talk to you for a long time of the gain to the taxpayer in the efficiency and the economy of the relief programs under local control, and the advantages of a spending unit being close to the source of revenue. The importance of the medical profession in any program of relief is emphasized by the following figures from my own county of Kent.

We sent a total of one million, seven hundred and thirty-six thousand, seven hundred and seventeen dollars for direct relief in the years of 1940, 1941, 1942 and 1943. Of this amount, $114,255 was for medical care. Hospitalization took approximately 25 per cent out of every relief dollar. In this program, we must rely entirely on your help.

In Kent County, we have the largest number of old age assistance cases in comparison to population of any county in the state of Michigan. This is due to the fact that our metropolis is an old furniture city and our average age is much higher than those counties with cities that have made rapid growth from the automobile industry.

In this county, we have 5,800 old age assistance cases in comparison to 14,000 in Wayne County and 3,000 in Genesee County which is comparable to Kent in population. For this number of old age assistance cases, it must be borne in mind that each one is a potential medical or hospital problem. This has also created a problem in home nursing care. This is also a problem in many other counties.

We have been extremely fortunate here that the Sisters of the Carmelite Order have taken an interest in this problem and they purchased a lot and have plans drawn to build a one hundred and twenty bed nursing home and we believe this will help solve our problem.

Kent County is outstanding in the fact that the depression started here in 1925 when many of our furniture factories were forced to close. Of the 48,000 case histories in our files, many of them date back to 1925 and prior years. In the winter of 1933 and 1934, we had 50,000 people on relief in Kent County, or one person out of five in comparison to the total population. At the end of this war, however, we will be in a much better position than many industrial counties who have had a great influx of people coming from the South to work in their defense plants. Many of these people are spending their money as fast as they earn it and having lived under conditions as they exist in the northern states and with the high wages they have been able to earn, will not be willing to return to their former homes, but will start drifting around the state to different localities. Each day, social welfare deparments will be confronted with many new problems.

I know that our state association would oppose any legislation taking away any of the powers we have obtained and we would also direct all of our efforts to defeat legislation proposing to socialize medicine. For instance, under our present law, clients are given the right to choose their own physician, and no one in need of medical care or attention is denied this right. In fact, on the recommendation of family doctors, we have rehabilitated a great many persons who because of some physical

condition are unable to work. In no way can you spend public funds more wisely than to assist some person who is handicapped, if by an operation or medical care he can once more regain self-respect in being able to work and support his family.

In closing, I wish to state that our strength is in organization, and with the State Association of Supervisors and our State Association of Social Welfare Boards and others who are interested and whose interests are being jeopardized by crackpot legislation, pooling our strength, we should be able to prevent the passage of laws detrimental to good government. It is for this reason that we should keep in close contact with other organizations, and while we may not agree on some things, there are many in which we are in accord.

I would propose that the executive committees of the three organizations and the others who have the same interests, should get together at least once a year and discuss proposed legislation of interest to all of us.

Now, I would like to say something about the remark your President made of this proposed initiatory petition that they are passing this fall. It is the easiest thing in the world to get petitions filed. Very seldom do they fail. I can speak for our State Association and in that association, we have about two hundred and fifty active members and about sixteen hundred associate members. Now, when I speak of the associate members, I am speaking of the State Association of Supervisors, and I am sure that both of these groups, if you gentleman are going into this fight, if we could meet—our board of directors and our executive committee and that of the State Association of Supervisors—that a large share of both of those organizations would be glad to back you in this fight.

THE SPEAKER: I am sure we all appreciate Mr. Dean's comments here and the very fine talk he has given. We will have it permanently in our records.

We come now to the oxering of resolutions, but if you will wait a moment, I would like to make an announcement. Dr. Novy has asked that it be announced that the financial report of the Michigan Medical Service is on the chairs and he asks that you take one so that you may study it before the meeting of the Michigan Medical Service tomorrow afternoon.

We are now ready for the offering of resolutions:

VIII. Resolutions

VIII—1. MEDICAL VETERAN READJUSTMENT PROGRAM

Resolution No. 1 was presented by A. E. Catherwood, M.D., of Wayne County.

WHEREAS, more than 2,100 Michigan doctors of medicine in the armed services, where they have performed so brilliantly, will be returning soon, and the medical profession and this House of Delegates are faced with the immediate responsibility, as well as the privilege, of preparing to assist them in a realistic manner, and

WHEREAS, a study of the situation shows that the returning doctor will be faced by any one or a combination of these three problems: Where to locate, further professional education, finances, and

WHEREAS, there are many projects under way by various hospital staffs, local county medical societies, State societies, American Medical Association, American College of Surgeons, American College of Physicians, and others, indicating the necessity for co-ordination, therefore be it,

RESOLVED, that necessary funds be allocated by the Council of the Michigan State Medical Society to procure the full-time services of a Counsellor on postwar adjustments, said counsellor to be a part of the regular executive administration of the State Society, and be it further

RESOLVED, that the Michigan State Medical Society request each county society to appoint a postwar adjustment committee to co-operate with the counsellor.

DR. CATHERWOOD: Warren Babcock, M.D., has given this problem a great deal of thought and he is the man who originally had the idea of the Council to co-ordinate all our efforts and this was presented to the Wayne delegation and they were unanimous in approval of the presentation of this resolution.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions. Are there any further resolutions?

IX. Amendments to Constitution and By-laws

IX—1. MEMBERSHIP FOR DISABLED VETERANS

(Chapter 8, Sec. 4

Resolution No. 2 was presented by C. L. Hess, M.D., of Bay.

WHEREAS, every reputable Doctor of Medicine, under license to practice medicine and surgery and midwifery by authority of the Michigan State Board of Registration in Medicine, is eligible for active membership in a component county society as provided in the Constitution, Article III, Section 2, and By-laws, Chapter 9, Section 3, irrespective of his being in active practice, although if not in active practice, he may be elected as Associate Member at the option of the component county society as provided in the Constitution, Article III, Section 4, and

WHEREAS, active members, becoming totally disabled while on active duty in the military forces of the United States, should have their state dues and assessments remitted,

BE IT RESOLVED, that Chapter 8, Section 4, of the By-laws be changed to read as follows:

"An active member in good standing shall not be required to pay his annual state dues and assessments during the years he is on active duty in the military forces of the United States and during the years he may be totally disabled immediately following such duty."

IX—2. PROCEDURE OF ETHICS

(Chapter 9, Sections 3 to 10 incl.; Chapter 5, Sec 4; Chapter 6, Sec. 9)

Resolution No. 3 was presented by C. L. Hess, M.D., of Bay.

WHEREAS, The Council has appointed a Special Committee to make a critical survey of the By-laws governing the procedures on unethical conduct and to recommend changes for the purpose of clarification and simplification of the procedures, and

WHEREAS, the present rules provide that a member, disciplined by his component county society, may appeal, first to the Councilor of his District, then to the Council, and finally to the Judicial Council of the American Medical Association, and whereas, a disciplined member should be allowed to appeal directly to the Council, so that the Councilor from his district may sit without prejudice at the hearing on an appeal which such member may make to the Council, and

WHEREAS, it is desirable to specify the length of term of members of the Committee on Ethics of the State Society and clarify the duties of the Committee,

BE IT RESOLVED, that Chapter 9, Section 3 of the By-laws have the third sentence of the first paragraph deleted and the procedure on disciplinary action by component county societies amended, so that Section 3 shall read as follows:

"Each component county society shall be the judge of the qualifications of its own members, but as such societies are the only portals to this Society and to the American Medical Association, every reputable practitioner of Medicine who meets the requirements specified in the Constitution, Article III, Section 2, shall be eligible to active membership.

"A component county society may expel, suspend, or otherwise discipline a member under such procedure as is specified in its Constitution and By-laws, provided he is served by registered mail with a written copy of the charges preferred against him, and given at least thirty days notice of a hearing at which he may offer defense against such charges. He may employ counsel. Efforts at conciliation and compromise shall precede all hearings.

"A member under disciplinary action may appeal to the Council of the State Society. However, such disciplinary action shall remain in effect during the time an appeal is pending. A report of the action taken shall be made by the component county society within thirty days to the Secretary of the State Society."

BE IT RESOLVED FURTHER, that Chapter 9, Section 4 of the By-laws be deleted and the following substituted therefor:

"A member of a component county society whose license has been revoked shall be dropped from membership automatically as of the date of revocation."

BE IT RESOLVED FURTHER, that Chapter 9, Section 5 of the By-laws be deleted and the subsequent Sections 6 to 10 be numbered 5 to 9, respectively.

BE IT RESOLVED FURTHER, that Chapter 5, Section 2 of the By-laws have the word "censor" deleted, so that the first sentence shall read as follows:

"Each Councilor shall be the organizer, advisor, and peacemaker for his district."

BE IT RESOLVED FURTHER, that Chapter 5, Section 4 of the By-laws be deleted and the procedure on appeal to the Council from disciplinary action be revised, so that Section 4 shall read as follows:

"A member disciplined by his component county society may file an appeal in writing to the Council within 90 days of such disciplinary order. This appeal shall be referred by the Council to the Committee on Ethics of the State Society for investigation and report. After giving at least 30 days' notice to the appealing member and his component county society, the Council shall hold a hearing on the appeal under such rules as it may adopt. The Council shall review the record of the original proceedings and may obtain additional evidence. Its decision shall be final except that within the next 90 days a further appeal may be made to the Judicial Council of the American Medical Association."

BE IT RESOLVED FURTHER, that Chapter 6, Section 9 of the By-laws be deleted and the following substituted therefor:

"The Committee on Ethics shall consist of eight members appointed by the President with the approval of the Council, each member to serve for a four-year term, so staggered that two members are selected annually, provided that: in 1944 the term of two members shall be for four years, two for three years, two for two years and two for one year, In case a vacancy

occurs before the expiration of a member's term the President shall appoint a successor to serve the unexpired portion of the term,

"The Committee shall render advisory opinions on questions of ethics submitted to it by the Council.

"On request of the Council it shall conduct an investigation, under rules approved by the Council, concerning the ethical conduct of a designated member of this Society and report its findings to the Council."

IX-3. COMMITTEE ON CANCER CONTROL
(Chapter 6, Sec. 6)

Resolution No. 4 was presented by C. L. Hess, M.D., of Bay.

BE IT RESOLVED, that the name of the "Committee on Cancer," as given in Chapter 6, Section 6 of the By-laws, be changed to the present name of this committee and read as follows: "Committee on Cancer Control."

IX—4. CHANGING "MEETING" TO "SESSION"
(Chapter 3, Sec. 7-M)

Resolution No. 5 was presented by C. L. Hess, M.D., of Bay.

BE IT RESOLVED, that Chapter 3, Section 7, paragraph m, first sentence of the By-laws have the words "session" and "meeting" interchanged, so that the first sentence shall read as follows:

"The election of officers shall be held at the last *meeting* of the House of Delegates at the Annual *Session.*"

IX-5. TERM OF MSMS'S REPRESENTATIVES TO JOINT COMMITTEE ON HEALTH EDUCATION
(Chapter 6, Sec. 5)

Resolution No. 6 was presented by C. L. Hess, M.D., of Bay.

WHEREAS, it is desirable to clarify the appointment and the length of terms of representatives on the Joint Committee on Health Education,

BE IT RESOLVED, that Chapter 6, Section 5 of the By-laws be revised, so that it shall read as follows:

"The Society's representatives on the Joint Committee on Health Education shall consist of five members, appointed by the President with the approval of the Council, each member to serve for a five-year term, so staggered that one member is selected annually, provided that in 1944 the term of one member shall be for five years, one for four years, one for three years, one for two years, and one for one year. In case a vacancy occurs, the President shall appoint a successor to serve the unexpired portion of the term."

IX-6. TERM OF MEMBERS OF COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION
(Chapter 6, Sec. 7)

Resolution No. 7 was presented by C. L. Hess, M.D., of Bay.

WHEREAS, the present Committee on Postgraduate Medical Education now consists of twelve members including a chairman and an assistant chairman and the length of the term of a member should be more clearly specified,

BE IT RESOLVED, that Chapter 6, Section 7 of the By-laws have the first paragraph deleted and the following substituted therefor:

"The Committee on Postgraduate Medical Education shall consist of twelve members, appointed by the President with the approval of the Council, each member to serve for a three-year term, so staggered that four members are selected annually, provided that in 1944 the term of four members shall be for three years, four for two years and four for one year. In case a vacancy occurs before the expiration of a member's term, the President shall appoint a successor to serve the unexpired portion of the term."

THE SPEAKER: These resolutions will be referred to the Committee on Amendments to the Constitution and By-Laws.

(Continued in January, 1945)

YOU AND YOUR BUSINESS

The 1945 Postgraduate Conference on War Medicine—The 80th Annual Session of the Michigan State Medical Society will be held in Detroit on September 19-20-21, 1945. The Book-Cadillac Hotel will be headquarters. The Woman's Auxiliary will also meet on September 19-20 with headquarters at the Statler Hotel, Detroit.

COUNTY SECRETARIES CONFERENCE, JANUARY 28

An extraordinary program (see page 1120) has been arranged for the Annual County Secretaries' Conference and School of Information, scheduled for the Book-Cadillac Hotel, Detroit, Sunday, January 28, 1945. This meeting is a MUST for Secretaries and Presidents of County Medical Societies. Moreover, its timely interest should attract other officers and members of Michigan's fifty-five county medical societies. All are cordially invited.

MEDICAL DIRECTORIES

"Who's Important In Medicine" of 320 Broadway, New York 7, is writing Michigan physicians that they are to be honored by having their names in the 1944 compilation of "Who's Important In Medicine." For information on this organization, contact the Executive Office, 2010 Olds Tower, Lansing 8.

Another firm sending postal-card questionnaires to Doctors is the *"Academy Publishing Bureau,* 509 Minnesota Street, St. Paul, Minnesota." The heading of the card is styled: "Academy-International of Medicine and Dentistry," with a subtitle of "Medical Section, Academy-International of Medicine." The recipient is told by the publisher that he is "one of a very limited number of practitioners from whom data is requested." Information on this activity is also available to members of the Michigan State Medical Society.

In Memoriam

KILLED IN ACTION

Bertram W. Morse of Whitehall was born in 1901 and was graduated from Wayne University College of Medicine in 1932. He located in Whitehall in 1934 and served as health officer for seven years and as vice president of the Whitehall Chamber of Commerce. He enlisted in May, 1942, and was given a captain's commission, rising to the rank of major one year ago. He was exceedingly interested in plastic surgery and hoped to specialize in that field when he returned to civilian life. He was killed in action in France August 29, 1944. Doctor Morse was the first Doctor of Medicine from Muskegon County to lose his life in the war.

Vito V. Stabile was born February 9, 1917 in Boston and was graduated from Wayne University College of Medicine. He interned at Grace Hospital from March to December, 1943. At the time of his death, June 19, 1944, he was serving as a Lieutenant in the Naval Reserve, Medical Corps, and was killed in action while transporting wounded from France to England following the recent D-Day Invasion.

Lloyd H. Childs of Flint was born August 31, 1886 at Adrian and was graduated from the University of Michigan Medical School in 1910. He practiced in South Dakota one year before going to Flint. He was medical director of Chevrolet Motor Division in Detroit for five years, and in Flint for twenty-eight years. He was a member of the American Association of Industrial Physicians and Surgeons and many other professional and civic organizations. He died September 18, 1944.

Robert C. Laird of Detroit was born in 1894 in Ireland and was graduated from Wayne University College of Medicine in 1928. He had practiced in Detroit the last sixteen years. Doctor Laird was a fine physician and had a large and enthusiastic following among his patients and his early demise will be much regretted by his friends in the medical profession.

William C. Martin of Detroit was born in 1870 and was graduated from Wayne University College of Medicine in 1890, after which he went to Berlin for postgraduate work. In 1894 he began teaching in Wayne University College of Medicine and continued until 1929. He had practiced medicine for fifty years in Detroit. He was elected to Emeritus Membership in

the Michigan State Medical Society in 1941. He died September 15, 1944.

Charles R. Sheridan of Detroit was born in Cumberland, Md., and was graduated from Georgetown University and the University of Maryland. He began his practice in 1906 for a mining corporation near his native city. In 1913 he went to Detroit and was a physician first at St. Mary's Hospital and later at St. Francis in Hamtramck which he was instrumental in building. He was health commissioner in Hamtramck for six years. He died October 3, 1944, after a long illness.

William A. Smith of Petersburg was born in Chagrin Falls, June 8, 1887, and was graduated from the Homeopathic Medical College in Cleveland in 1903. He located in Petersburg after his graduation, where he built up a large practice. Doctor Smith served as president of Monroe County Medical Society in 1926-27. He became president of the H. C. McLachlin & Co. State Bank in 1930, which position he held until his death. He had served for twenty-one years as a member of the school board and was active in many civic organizations. He died on July 9, 1944.

John N. Swartz of Detroit was born in 1871 at Barnesville, Pa., and was graduated from the University of Michigan Medical School in 1892. After graduation he located in Detroit, where he had practiced until the time of his death, September 26, 1944.

WHOLE BLOOD FLOWN DIRECT TO PARIS

Blood from American civilians is now flowing through the veins of soldiers wounded in Europe within twenty-four hours after it is donated in this country! On October 12 the Army Transport Command began flying whole blood direct to Paris instead of first to a relay station in Scotland. As a result the blood is available for transfusion within 24 hours after it is drawn from "O" type donors in Boston, New York and Washington. More than 750 pints are now being flown across daily—but the need for both whole blood and plasma is becoming more and more urgent as the number of casualties increases.

GRANT TO WAYNE UNIVERSITY

Acceptance of a $3,000 grant to the Wayne University College of Medicine from Merck and Company, Incorporated, was approved by the Board of Education at its last meeting. The fund will be used in the department of surgery for a clinical investigation of antibiotics and streptolysin.

Woman's Auxiliary

THE SEASON'S GREETINGS

May the holiday season bring you joy; if not the merry Christmas of former years, at least the joy that achievement brings.

The knowledge that we, as auxiliary members, have endeavored to maintain a cheerful home for our families, have assumed a fair share of the war effort, and are striving to preserve the American way of life—which our soldiers are fighting for—should bring a deep sense of happiness to all of us.

My very best wishes for a happy Christmas and for all the days of the coming year!

LELA FRENCH

* * *

Have you received your copy of the *Auxiliary News?* If not, please notify Mrs. C. F. DeVries, Box 430, R. R. 1, Lansing, and one will be mailed to you.

THE GRAND RAPIDS MEETING

The eighteenth annual meeting of the Woman's Auxiliary to the Michigan State Medical Society was held in Grand Rapids, September 27-28, 1944, at the Hotel Pantlind.

Registration opened on Tuesday at 1:00 p.m. under the capable chairmanship of Mrs. John Ten Have. She reported sixty-one delegates, 146 members and seven guests present.

A dinner for the Past Presidents and Secretaries Club was held Tuesday evening at 6:30 o'clock in the Country House. Mrs. Guy L. Kiefer, honorary state president and present president of the club, presided. Mrs. Wm. J. Butler, Mrs. H. J. Pyle, Mrs. A. V. Wenger, and Mrs. Carl Snapp entertained at a pre-dinner party in the home of Mrs. Butler.

1943-1944 Board members and county presidents were complimented at the pre-convention Board meeting and luncheon held in the Schubert Room. All members were welcome to attend.

Members of Kent County Auxiliary were hostesses at a tea in honor of Mrs. David W. Thomas, President of the Woman's Auxiliary to the American Medical Association in the Continental Room. The tea table was decorated with a large white bowl filled with gladioli. Mrs. Merrill Wells and Mrs. Lynn A. Ferguson poured. Following, Mrs. Richard Gregory presented a costume impersonation of the first woman doctor of mysterious Mayaland, Consuelo Vadillo. This was thoroughly enjoyed.

Wednesday evening at 7 o'clock, Mrs. John J. Walch presided at the informal banquet in the Grill Room. The tables were beautifully decorated with arrangements of chrysanthemums and vegetables. The national anthem was led by Mrs. Thomas C. Irwin and Mrs. William R. Torgerson. Invocation was given by Mrs. Guy L. Kiefer. Mrs. Dixon gave the address of welcome, after which past presidents and honored guests were presented, one being Dr. A. S. Brunk, president of the Michigan State Medical Society. Mrs. Alexander M. Martin presented a very delightful fashion review during the dinner. Mrs. David W. Thomas, the national president, spoke of the development and growth of the organization of the Auxiliary and explained the two major projects for the year: (1) Juvenile Delinquency—"Prevention from the Medical Aspect," and (2) The Physical Fitness Program. She said, "Keep health leadership where it belongs, with the medical profession." She suggested reading the article "Keep Fit and Like it," in the September issue of *Hygeia.* The banquet adjourned in time for members to attend the Officers' Night program of the Michigan State Medical Society.

The convention was formally opened Thursday at 9:00 a.m. in the Amber Room by Mrs. John J. Walch, state president. The Pledge of Allegiance was conducted by Mrs. W. Sherman of Detroit. Dr. Frank E. Reeder, chairman of the Advisory Council, welcomed the Auxiliary. Mrs. Merrill Wells, president of Kent County, welcomed the members. Mrs. Lloyd C. Harvie, Saginaw, gave the response.

The "In Memoriam" service was given by Mrs. Homer Stryker of Kalamazoo.

Mrs. Willis Dixon, Grand Rapids convention chairman, thanked her committees. The minutes of the seventeenth annual meeting were read by Mrs. Otto Hult. Mrs. Homer Ramsdall, Manistee, read the convention Rules of Order.

Mrs. Walch, in her president's message, stated that she had visited seventeen counties and attended the midyear board meeting of the AMA, the midyear board meeting of the Michigan Auxiliary, the AMA Auxiliary convention, the School of Information in January in Detroit, and a meeting of the Michigan Nursing Council of War Service. Two issues of the *Auxiliary News* were edited. She wrote 300 letters and fifty cards. She praised the counties for their activities and urged their continuance for the coming year.

State chairmen and county presidents gave reports. Officers for the coming year are as follows:

President—Mrs. H. L. French, 1620 W. Main St., Lansing 15

President-elect—Mrs. Lloyd C. Harvie, 417 Arduasi, Saginaw

Vice President—Mrs. R. H. Alter, 801 S. West Ave., Jackson

Honorary President—Mrs. Guy L. Kiefer, 834 Rosewood Ave., East Lansing

(Continued on Page 1110)

Past President—Mrs. John J. Walch, 709 Fifth Ave., Escanaba

Treasurer—Mrs. Robert Novy, 2910 Iroquois Ave., Detroit

Secretary—Mrs. C. F. DeVries, Box 430, R. R. 1, Lansing

Mrs. H. L. French gave a report on the AMA Auxiliary convention held in Chicago.

At 12:30 o'clock, the annual luncheon was held in the Grill Room with Mrs. John J. Walch presiding. The National Anthem was led by R. J. McCandliss, M.D., accompanied by Mrs. McCandliss. Rev. Edward A. Mohns gave the invocation. Professor Floyd E. Armstrong, professor of economics at the Massachusetts Institute of Technology, spoke on "Women in the Postwar Economic World." His message was, "Inform yourself about the economics of your own home."

The post convention Board meeting was held in the Amber Room at 3:30 with Mrs. H. L. French, the new president, presiding State chairmen and county presidents of 1944-1945 told of their plans for the coming year.

Mrs. H. L. French entertained at a tea honoring Mrs. John J. Walch following the board meeting.

Great credit is due Mrs. John J. Walch, Mrs. Willis L. Dixon and the Kent County Auxiliary for an outstanding convention.

Wayne County.—A luncheon at the Whittier Hotel, October 13, opened the season of 1944-45. A board meeting at 10:30 a.m. preceded the luncheon. Lillian Beal Hicks gave a program of Dolly Madison. Mrs. Hicks is widely known as a coloratura soprano as well as for her dramatic ability.

The Ways and Means Committee on October 20 sponsored a rummage sale, proceeds of which are being used for war projects including the rehabilitation program at Percy Jones Hospital at Battle Creek.

St. Clair County.—The Auxiliary joined with the St. Clair County Medical Society for dinner at Wesley Hall, First M. E. Church, Port Huron, October 10, followed by an address, "What Price Security," by Professor Floyd E. Armstrong. The dinner and meeting were open to the public.

SURGICAL TREATMENT OF GALL-BLADDER DISEASE

(Continued from Page 1088)

now it is in the neighborhood of 3 per cent in most good clinics. When complications have developed prior to operation, the mortality rate rises.

In the vast majority of patients, the relief of symptoms following cholecystectomy is complete and gratifying to both patient and surgeon. Unfortunately we have all seen the occasional patient who is not relieved of symptoms or who is worse after operation than before. Failure to achieve a satisfactory result is most frequently due to failure to make a satisfactory diagnosis, i.e., to remove a gall bladder which is nearly normal, and overlook some other cause such as pancreatitis, duodenitis, spastic colitis or some other abnormality. Careful evaluation of the evidence of cholecystic disease before operation is the most effective way to avoid this pitfall. Another cause of poor results is a poorly performed operation, such as overlooking a stone in the common duct, incomplete removal of the gall bladder, or extensive trauma at the time of operation leading to excessive production of adhesions. With accurate diagnosis and a satisfactorily performed operation, good results should be expected and attained.

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✶ COUNTY AND PERSONAL ACTIVITIES ✶

Gordon B Myers, M.D., Detroit, is co-author of an original article entitled "The Male Climacteric, Its Symptomatology, Diagnosis and Treatment," which appeared in JAMA of October 21, 1944.

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Raymond W. Waggoner, M.D., Ann Arbor, is co-author of an original article entitled "Psychiatric Selection of Men for the Armed Forces," which appeared in JAMA of September 23, 1944.

* * *

The Michigan State Board of Registration in Medicine announced on October 27 the revocation of the license of Marshall Cullen Sexton, M.D., of Columbus, Ohio, and the suspension for one year of the license of Guy Garland Alway, M.D., of Ann Arbor, and the suspension of the license of LeRoy Wellstad, M.D., of Ottumwa, Iowa, for violations of the Medical Practice Act.

* * *

The Second Annual Clinical Conference of the Chicago Medical Society will be held at the Palmer House, Chicago, on February 27, 28 and March 1, 1945. The sponsoring of this Conference for physicians of the Middle West has become an important function of the Chicago Medical Society following its inauguration last Spring. The Committee is already under way in securing speakers on important subjects for the 1945 session to which all members of the Michigan State Medical Society are cordially invited.

* * *

Urology Award.—The American Urological Association offers its annual award "not to exceed $500" for an essay on the result of some specific clinical or laboratory research in Urology. Competitors are limited to residents in Urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. Essays must be in the hands of Secretary Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1945.

* * *

Lawrence Reynolds, M.D., Detroit, was guest speaker at the Eleventh Annual Postgraduate Day of the Medical Institute of the University of Toledo, held in Toledo, Ohio, on November 3. Dr. Reynold's subject was "Pseudo Fractures and some Medical Legal Problems in connection with General Practice."

This year's Institute was dedicated as a memorial to the late John T. Murphy, nationally recognized pioneer in radiology, who died in June.

* * *

"*Strikes* have been so numerous throughout the United States since Pearl Harbor, all of which have involved either directly or indirectly the production of material

and supplies sorely needed by the service branches of the Government, that it can readily be assumed that subversive activities are on such a huge scale that they are undermining our constitutional form of government, the free enterprise system, the right to work, enjoy the unmolested sanctity of our homes, and a suspension of the seizure of property without due process of law."—Detroit Board of Commerce, May 18, 1944.

* * *

Committees of The Council, Michigan State Medical Society, 1944-45:

Finance Committee: C. E. Umphrey, M.D., Chairman, W. E. Barstow, M.D., T. E. DeGurse, M.D., W. H. Huron, M.D., A. B. Smith, M.D.

Publication Committee: Ray S. Morrish, M.D., Chairman, O. O. Beck, M.D., A. H. Miller, M.D., Dean W. Myers, M.D., R. C. Perkins, M.D.

County Societies Committee: O. D. Stryker, M.D., Chairman, Wilfrid Haughey, M.D., R. J. Hubbell, M.D., P. A. Riley, M.D., E. R. Witwer, M.D.

* * *

Michigan speakers on the program of the Fifty-fifth Annual Meeting of the Association of American Medical Colleges, held in Detroit October 23, 24, 25, were: Gordon B. Myers, M.D., L. S. Woodworth, M.D., and Daniel E. Hasley, M.D., all of Detroit.

A. C. Furstenberg, M.D., of Ann Arbor was inducted into the presidency of the Association at the Detroit meeting.

Tit for Tat—A physician in another city recently received three neckties unordered from an eastern mail order house. Accompanying the ties was a letter reading as follows: "Dear Doctor: We are taking the liberty of sending you three exceptionally fine ties. We know you will like them. Please send us $2." Here is the physician's reply: "I am taking the liberty of sending you $2 worth of extra fine pills. These pills have helped thousands and I am sure you will appreciate my thoughtfulness in sending them to you. Please accept them in payment of the ties you sent me."

* * *

An appreciation to the MSMS Committee on Postgraduate Medical Education: "Yesterday I received a certificate of Fellowship in Postgraduate Education issued by the Michigan State Medical Society. I was really thrilled on receiving this and I prize very much the work that I took under the direction of your Committee which this Fellowship represents. Thanks a lot for your kind letter of congratulations. Although at the present time I am some distance from the state of Michigan, I am still much interested in the educational program carried on by the Medical Society there." —Lyle C. Shepard, M.D., Glendale Sanitarium and Hospital, Glendale, California.

* * *

A. S. Brunk, M.D., president of the Michigan State Medical Society, was guest speaker at the AMA Secretaries' Conference of November 17-18. His subject was

"Radio Advertising by the Medical Profession," in which he outlined the experiment of the Michigan State Medical Society in purchasing radio time to bring to the poeple dramatized incidents in the lives of private practitioners of medicine.

Dr. Brunk also was guest speaker at the session of the House of Delegates of the Iowa State Medical Society held in Des Moines on November 1. He outlined the work of Michigan Medical Service. He also spoke on invitation to the Permanent Study Committee on Health Insurance of the Indiana State Medical Association on November 12 in Indianapolis concerning the formation, principles and activity of Michigan Medical Service.

* * *

Radio Presentations sponsored by the MSMS Radio Committee (Russell N. DeJong, M.D., Chairman), during November and December are as follows:

November 2—Dr. Otto K. Engelke, Health Officer, Washtenaw County Health Department, Ann Arbor: The Role of the Parent in the Control of the Dangerous Contagious Diseases.

November 9—Miss Rhoda F. Reddig, Professor of Nursing and Director of the University of Michigan School of Nursing: Some Answers to Questions Concerning Nursing.

November 16—Dr. Gordon K. Moe, Assistant Professor of Pharmacology in the University of Michigan Medical School: Recent Advances in the Treatment of Thyroid Disease.

November 23—Thanksgiving.

November 30—Dr. Carl A. Moyer, Director of Surgery at the William J. Seymour Hospital, Eloise, Michigan: The Dog and Modern Medicine.

December 7—Dr. Herman H. Riecker, Assistant in Postgraduate Medicine in the University of Michigan: The Prevention of Heart Disease in Middle Life.

December 14—Dr. Paul S. Barker, Associate Professor of Internal Medicine in the University of Michigan Medical School: Recent Advances in the Care of Heart Disease.

December 21—Dr. Joseph G. Molner, Deputy Commissioner and Medical Director, City of Detroit Department of Health, and Assistant Professor of Preventive Medicine and Public Health in the Wayne University College of Medicine: Protection of Children Against Disease.

December 28—Dr. Loren W. Shaffer, Director of Social Hygiene Division, City of Detroit Department of Health, and Professor of Dermatology and Syphilology in the Wayne University College of Medicine: The National Program for Venereal Disease Control.

* * *

PHYSICAL REHABILITATION

The Medical Advisory Committee of Physical Rehabilitation met October 22, 1944, to study the subject. The Federal Government is interested in this subject, and has provided by law that the best of services

shall be made available for rehabilitation of physically handicapped persons, and this applies to those handicapped from all sorts of causes, other than war casualties. This rehabilitation program is now estimated at about ten per cent of the patients that visit the doctors' offices, but it is expected that it will soon be twenty-five per cent. This is a program that all the doctors are of necessity interested in.

POSTGRADUATE EDUCATION

Butterworth Hospital, Grand Rapids, sent a news letter to all its staff men in the services on August 12, 1944, as follows: "Your hospital is now approved by the American College of Surgeons for graduate training in surgery. We had been previously approved by the Council on Medical Education and Hospitals of the American Medical Association, so this new approval by the College makes us fully approved by all rating "bodies."

There is a committee of the Michigan State Medical Society to study and make recommendations for postgraduate training for our returned medical officers. Any who wish residency or postgraduate training should write to Dr. B. R. Corbus, chairman, telling what type of training he is mostly interested in, and the committee and society will do its best to see that it is forthcoming.

MEDICAL WOMEN'S ASSOCIATIONS MERGE

On Tuesday, October 24, an amalgamation of the Blackwell Society of Detroit and the Michigan Branch of the American Medical Women's Association was effected. The new organization is to be known by the name "The Blackwell Branch 20, of the American Medical Women's Association." Dr. Hallie Hartgraves, Regional Director of the A.M.W.A. in this area, presided at the meeting. The following officers were elected:

President.....Dr. Harriet E. McLane
Vice President.....Dr. Rose E. Herrold
Treasurer.....Dr. Delma F. Thomas
Secretary.....Dr. Esther H. Dale
President-Elect.....Dr. Fanny Kenyon

Additional members to serve on the Board were elected as follows: Dr. Mary B. Campbell, Dr. Frances L. MacCracken, Dr. Martha Wells, and Dr. Bertha Selmon.

THE "NATIONAL MEDICAL SOCIETY"

"The Directors of the National Medical Society cordially invite Dr. X to membership in the National Medical Society," reads an invitation mailed gratuitously to a number of doctors of medicine during the past several months. The invitation states, "Please reply to Dr. Hans Zimmerman, Executive Secretary, National Medical Society, 116 South Michigan Ave., Chicago 3, Ill."

The invitation further states, "The National Medical

Society welcomes to its membership all ethical members of the medical profession, regardless of medical creed. Homeopathy, Eclecticism, Osteopathy, and Naturopathy (physical medicine) all have an honored place and responsibility in the field of therapeutics." Further, it states, "The membership dues are $10.00 the first year and $6.00 annually thereafter."

A clipping from *The Chicago Tribune* of August 20, 1943, shows a picture of Hans Zimmerman, referred to in the newspaper item as a naturopathic physician "who had made his home in Chicago since he was released suddenly by the federal bureau of investigation from the Army's custody last March." According to Zimmerman's statement as quoted in this item, he was born in Germany and came to this country in 1927. The statement attributed to him in the newspaper clipping was a long recital of what happened to him at the time he apparently was interned at Camp McCoy.

Another clipping, taken from the *Rochester, New York, Democrat and Chronicle* for August 17, 1944, gives an account of a celebration of the 76th birthday of Bernarr Macfadden. Among those who, according to the newspaper clipping, were present on that occasion was one "Dr. Hans Zimmerman, who presented an honorary life membership certificate in the National Medical Society to Mr. Macfadden."

* * *

COUNCIL AND COMMITTEE MEETINGS

Advisory Committee on Radio of Public Relations Committee—Detroit, August 29.

Postwar Education Committee, Statler Hotel—Detroit, September 14.

Maternal Health Committee, Pantlind Hotel—Grand Rapids, September 28.

Venereal Disease Control Committee, Pantlind Hotel—Grand Rapids, September 28.

The Council, Pantlind Hotel—Grand Rapids, September 25, 28.

Executive Committee of The Council, Book-Cadillac Hotel—Detroit, October 11.

Medical Advisory Committee on Physical Rehabilitation—Porter Hotel, Lansing, October 22.

Maternal Health Committee, Wayne County Medical Society—Detroit, October 26.

Committee on Scientific Work, Porter Hotel—Lansing, November 5.

Insurance Panel Committee—Detroit, November 9.

Executive Committee of The Council, Book-Cadillac Hotel—Detroit, November 9.

Procurement and Assignment Committee, Book-Cadillac Hotel—Detroit, November 9.

Medical Advisory Committee on Rehabilitation—Porter Hotel, Lansing, December 3.

Legislative Committee, Wayne County Medical Society—Detroit, December 7.

Coming Meetings

Annual Session of The Council, Book-Cadillac Hotel—Detroit, January 25, 26, 27, 1945.

Legislative Committee, Book-Cadillac Hotel—Detroit, January 27, 1945.

Annual County Secretaries' Conference—Book-Cadillac Hotel, Detroit, January 28, 1945.

COUNTY SECRETARIES' CONFERENCE

The MSMS Annual County Secretaries' Conference and School of Information will be held at the Book-Cadillac Hotel, Detroit, on Sunday, January 28, 1945. County medical society secretaries, presidents and editors will be particularly interested in this socio-economic conference for which an excellent program is being arranged.

Tentative Program

9:30 a.m. to 5.30 p.m.

1. "First Things First"—W. W. Bauer, M.D., Chicago, Director, Bureau of Health Education of American Medical Association.
2. "The Selling Job of the Michigan Medical Profession—What Must Be Done *NOW*"—John F. Hunt, Chicago, Executive and Director of Research, Foote, Cone, & Belding.
3. "The Aims and Purposes of the Michigan Physicians Committee"—Edward F. Stegen, Chicago, Associate Administrator of National Physicians Committee.
4. "The Proposed Amendment to the Constitution of the State of Michigan"—Paul D. Bagwell, East Lansing, Director of Speech Department, Michigan State College.
5. "The Work of the Washington Office of the Council on Medical Service and Public Relations"—Joseph S. Lawrence, M.D., Washington, D. C., Director, Council on Medical Service and Public Relations, American Medical Association.
6. "The Physical Rehabilitation Program of the Federal Government"—E. F. Sladek, M.D., Traverse City, Michigan, Chairman of The Council, Michigan State Medical Society.

Two discussion periods will be held, one immediately before the noon-day dinner, scheduled for the Book-Cadillac Hotel at 12:00 Noon, and the second between 3:30 and 4:30 p.m.

All members of the Michigan State Medical Society and of the Woman's Auxiliary are cordially invited to attend the Conference of January 28 in Detroit.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

PRESCRIPTION FOR PERMANENT PEACE. By William S. Sadler, M.D., Consulting Psychiatrist, Columbus Hospital; Author, Theory and Practice of Psychiatry, The Mind at Mischief, Living a Sane Sex Life, Growing Out of Babyhood, et cetera. Chicago: Wilcox and Follett Co., 1944. Price 2.50.

Dr. Sadler is a practical psychiatrist, seeing the simple and obvious as well as the intricate; and abhoring large impressive words which mean nothing to the average person. Here he is seeing nations as he has been trained to see individuals. His ideas are interesting and challenging. For your relaxation and entertainment this book should be read. It will disturb your reveries, and set you to some real thinking.

* * *

OPERATIONS OF GENERAL SURGERY. By Thomas G. Orr, M.D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas. 723 pages with 1,396 step-by-step illustrations on 570 figures. Philadelphia and London: W. B. Saunders Company, 1944. Price $10.00.

This is a very fine piece of work for the busy practicing general surgeon. While Dr. Orr makes no pretense of covering all of the fine points of each specialty in surgery yet he is plenty comprehensive enough to include all of the necessary knowledge for the practicing surgeon in the field. Every essential operation is covered clearly, simply, and concisely as to indications, anatomy, technique, and pitfalls.

While the author has devoted the greater part of this book to operational technique, yet there is enough other material to make it much worth while from many other angles. For instance, his chapter on wound healing and suture material are more than helpful in orienting one right up to the present. His lucid description of surgical pitfalls constitutes warning enough to make the untrained man stay away from situations where he doesn't belong.

Certainly this is a book which can well be on any doctor's shelf.

MANUAL OF MILITARY NEUROPSYCHIATRY. Edited by Harry S. Solomon, M.D., Professor of Psychiatry, Harvard Medical School; Medical Director of the Boston Psychopathic Hospital; and by Paul I. Yakovlev, M.D., Clinical Director. Walter E. Fernald State School; Instructor in Neurology at the Harvard Medical School. With collaborators. Philadelphia and London: W. B. Saunders Company, 1944. Price $6.00.

The present manual has been prepared primarily as a reference textbook on topics of clinical neurology and psychiatry, and especially for medical officers in service remote from libraries and references. Part III—Administration and Disposition—had to be curtailed for there is much information not now suitable for publication. The same holds for the part about Prophylaxis and Therapy of neuropsychiatric casualties. The administration of induction stations is by a medical officer, and forms a basis for the study of all sorts of abnormal behavior states as they appear in mili-

tary service. The book is compact, but has over seven hundred pages of useful material.

CLINICAL UROLOGY. By Oswald Swinney Lowsley, A.B., M.D., F.A.C.S., Attending Surgeon of the Department of Urology (James Buchanan Brady Foundation) of the New York Hospital. Drawings by William P. Didusch. Second Edition, Volume 1-Vol. 11. Baltimore: The Williams & Wilkins Company, 1944. Price $10.00 per set.

This two-volume set of books is one of the most practical expositions of the anomalies and diseases of the genito-urinary tract. It is written for the specialist with full knowledge that the busy general practitioner will have to consult it often, and the wording and descriptions are in keeping. Diagnosis is given full consideration but the stress is on modern and effective treatment, with especial attention to the chemotherapy of the last few years. Up-to-date references are included for the benefit of the trained urologist.

TEXTBOOK OF GYNECOLOGY. By Emil Novak, M.D., F.A.C.S., Associate in Gynecology, the Johns Hopkins Medical School, Bon Secours and St. Agnes Hospitals, Baltimore; Second Edition. Baltimore: The William & Wilkins Company. 1944. Price $8.00.

The demand for a second edition of this work speaks for its excellence. Two new chapters have been added, and much new material throughout the book, which is larger than its predecessor. The subjects of gynecology and female endocrinology have been treated not only for the needs of the medical student but for the practitioner as well. The details of diagnosis and treatment have been especially emphasized. Illustrations are good and profuse.

GYNECOLOGICAL AND OBSTETRICAL UROLOGY. By Houston S. Everett, A.B., A.M., M.D., Associate Professor of Gynecology, The Johns Hopkins University, and Associate in Gynecology, the University of Maryland; Assistant Visiting Gynecologist and Gynecologist in Charge of the Cystoscopic Clinic, The Johns Hopkins Hospital. Baltimore: The Williams & Wilkins Company, 1944. Price $6.00.

There have been abundant and voluminous volumes on Urology, covering to some extent the question as it related to female patients. Dr. Everett has brought us a volume of exceptional interest and value, because it is confined to the deformities and diseases of the genito-urinary tract in especial reference to obstetrics and gynecology. The material for this work has accumulated while teaching at Johns Hopkins, and is beautifully presented, with descriptions of the use of the Kelly cystoscope, outstanding illustrations of the conditions and procedures described, and profuse use of the x-ray. The book pays minute attention to treatment and prognosis. A book for the use of the general man who needs help, and a reference and guide for the obstetrician and gynecologist whose patients want relief from obscure conditions.

DISEASES OF THE DIGESTIVE SYSTEM. Edited by Sidney A. Portis, B.S., M.D., F.A.C.P., Associate Professor of Medicine, University of Illinois Medical School (Rush), Attending Physician, Michael Reese Hospital, Consulting Physician, Cook County Hospital; Consultant in Medicine to the Institute of Psychoanalysis, Chicago. Illustrated with 182 Engravings. Philadelphia: Lea & Febiger, 1944. Price $11.00.

This new edition of Dr. Portis' textbook on diseases of the digestive system gives a clear foundation for the understanding of the psychosomatic bearings of gastro-intestinal complaints. The war has given the gastro-enterogolist an opportunity to study the changes in young adults brought about by emotional stress, and these features are discussed by the contributors in connection with their sections of the book. The history of gastro-intestinal observations and studies is followed from the first papyri to the latest investigations. Diagnosis, prognosis, treatment are emphasized. This is a standard-sized textbook with approximately fifty contributors, rich in references, and orderly in workmanship and execution.

PLASTER OF PARIS TECHNIQUE. By Edwin O. Geckeler, M.D., Associate Professor of Orthopedic Surgery, and Chief of the Fracture Service, Hahnemann Medical College and Hospital, Philadelphia. Fellow of the American Academy of Orthopaedic Surgeons, Fellow of the American Association for the Surgery of Trauma, Diplomate of the American Board of Orthopaedic Surgery. Baltimore: The Williams & Wilkins Company, 1944. Price $3.00.

The use and application of plaster of Paris is fully described in this small, but well-illustrated volume. The study of means and materials for plaster of Paris dressings is given full attention, and the pitfalls in application of dressings are pointed out with reasons and means to avoid them. It is a most practical book, and a ready guide to satisfactory work.

THE DIAGNOSIS AND TREATMENT OF ACUTE MEDICAL DISORDERS. By Francis D. Murphy, M.D., F.A.C.P., Professor and Head of the Department of Medicine, Marquette University School of Medicine, and Clinical Director of the Milwaukee County General Hospital and Emergency Unit, Milwaukee, Wisconsin. Philadelphia: F. A. Davis Company, 1944.

As a teacher and clinical director Dr. Murphy has noted that chronic diseases are usually well handled by the average practitioner, while acute ones are a problem not so well understood. For that reason he has written this book with the aim to pass on to the practitioner diagnostic procedures and methods of treatment found helpful. Acute conditions come with such suddenness that the practitioner must have at hand a store of general knowledge, and be prepared to act promptly. Diagnosis and treatment are stressed in acute conditions as they occur, and for study purposes, they are considered as systems: The heart, metabolic disorders, the kidneys, the lungs, acute abdominal emergencies, acute infections, tropical diseases, and acute poisoning. A chapter is devoted to drugs used in these various conditions. There is a page devoted in tabular form to the uses of the sulfonamides, and another to their toxicity. This is a very practical book, full of ideas and experience-proved methods.

INTERNAL MEDICINE IN GENERAL PRACTICE. By Robert Pratt McCombs, Lieutenant, Medical Corps, United States Naval Reserve; Recently Instructor in Internal Medicine for the Statewide Postgraduate Program of the Tennessee State Medical Association. On leave of absence from the staffs of the Pennsylvania Hospital, the Abington Memorial Hospital and the Jefferson Medical College, Philadelphia. 694 pages with 114 illustrations. Philadelphia and London: W. B. Saunders Company. Price $7.00.

The methods of the internist are applied to general practice, including notes on the necessity of careful histories, simple but efficient clinical methods, and a careful evaluation of the diagnosis, avoiding the snap judgment, and thus saving much time for the doctor and the patient. The author is an officer in the Navy and the book carries a foreword by Admiral McIntire. It is well done, and a valuable book.

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